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Thirty-ninth Parliament, 2006

SENATE OF CANADA

Proceedings of the Standing Senate Committee on

Social Affairs, Science and Technology

Chair:
The Honourable MICHAEL KIRBY

Monday, May 8, 2006

Issue No. 2
Volume 3 of 5

SECOND REPORT OF THE COMMITTEE
(Final report on mental health, mental illness and addiction entitled:
OUT OF THE SHADOWS AT LAST
Transforming Mental Health, Mental Illness and Addiction Services in Canada — Part III, Chapters 9 and 10, and Part IV)

Première session de la
trente-neuvième législature, 2006

SÉNAT DU CANADA

Délibérations du Comité sénatorial permanent des

Affaires sociales, des sciences et de la technologie

Président :
L'honorable MICHAEL KIRBY

Le lundi 8 mai 2006

Fascicule n° 2
Volume 3 de 5

DEUXIÈME RAPPORT DU COMITÉ
(Rapport final sur la santé mentale, la maladie mentale et la toxicomanie intitulé :
DE L'OMBRE À LA LUMIÈRE
La transformation des services concernant la santé mentale, la maladie mentale et la toxicomanie au Canada — partie III, chapitres 9 et 10, et partie IV)

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Published by the Senate of Canada

Available from: Public Works and Government Services Canada
Publishing and Depository Services, Ottawa, Ontario K1A 0S5

Also available on the Internet: http://www.parl.gc.ca

Publié par le Sénat du Canada

Disponible auprès des: Travaux publics et Services gouvernementaux Canada –
Les Éditions et Services de dépôt, Ottawa (Ontario) K1A 0S5

Aussi disponible sur internet: http://www.parl.gc.ca

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PART III

Service Organization and Delivery

9.1 INTRODUCTION

> *One of the biggest challenges for addictions in the health system is that ministers have to choose between MRIs and junkies, to be blunt. There is no political traction…—Michel Perron*[376]

In Canada, the treatment of addiction, like that of mental health, is not a "system." Its evolution has been fragmented, chronically underfunded, and has occurred in the shadow of stigma and government inattention. Yet, there are few Canadian families who have not been touched by addiction.[377] Over the course of its hearings, the Committee heard much about the devastation caused by addiction: family breakdown, financial losses, child prostitution, crime, homelessness, domestic violence and child abuse, concurrent health problems, road and industrial accidents, job loss, birth defects, brain damage and suicide. The connection between addiction and these consequences often goes unrecognized because of stigma and denial. When people with addictions come to the point where they need and will accept help, they and their families have a hard time finding services; even when successful, they often face long waiting lists. Lengthy wait times mean those who might otherwise be helped, withdraw further into addiction with a resulting increase in the human and social consequences.

When people with addictions come to the point where they need and will accept help, they and their families have a hard time finding services; even when successful, they often face long waiting lists.

30% of people diagnosed with a mental illness will also have a substance abuse problem in their lifetime, and 37% of people who abuse alcohol (53% who abuse drugs) also have a mental illness.

Mental health and addiction services operate in separate spheres. The idea that some people with a substance abuse problem might also have a mental illness and that those living with mental illness might also be addicted has taken time to emerge. However, research has revealed that 30% of people diagnosed with a mental illness will also have a substance abuse problem in their lifetime, and 37% of people who abuse alcohol (53% who abuse drugs) also have a mental illness.[378]

When mental illness and an addiction are present together, there is the added burden of being shunted back and forth.

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376 21 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/28ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

377 Throughout this chapter, the term "addiction" is used for simplicity's sake. It is recognized that harm due to substance use and abuse can occur without addiction being present: through binge drinking, intoxication and unsafe drug use that result in health problems, road accidents, falls and other adverse consequences. Substance use exists on a continuum with limited, safe use at one end and addiction at the other — but the potential for harm may occur at many points along this continuum.

378 Skinner, W., O'Grady, C., Bartha, C., and Parker, C. (2004) Concurrent substance use and mental health disorders: An information guide. Toronto: Centre for Addiction and Mental Health.

Consumers and families are frustrated trying to get help from mental health services or from addiction services. But when mental illness and an addiction are present together, there is the added burden of being shunted back and forth as professionals argue over which problem constitutes the "primary" diagnosis.

> *I've gotten help for each individual thing but to get help for (both), like at the same time, you fall between the cracks and if one of your disorders is worse than another and then one doctor thinks you're seeing somebody else, basically nobody's helping you, nobody follows up, you kind of disappear. —Anonymous*[379]

The Committee acknowledges that it has not been able to devote as much attention to substance use issues as it intended when it embarked on its study of "mental health, mental illness and addiction." The Committee recognizes that this report concentrates primarily on mental health issues and is acutely aware that it only scratches the surface of many substance use issues that deserve a much fuller treatment.

There are, of course, many areas of overlap between mental health and substance use issues, not least of which involve people living with both mental health and substance use disorders. Because of the importance of substance use issues in general, and of this overlap in particular, this chapter of the report is devoted to these issues. Moreover, there is an important recommendation in Chapter 16 (National Mental Health Initiatives) that the federal government inject an additional $50 million per year in concurrent disorder programs.

9.2 THE HUMAN FACE

A strong consumer and family self-help and advocacy movement has arisen in support of mental health services. With regard to addiction, too, self-help has had a pervasive presence with a long history — but within a culture of anonymity and independence, and with little government funding. This may explain why so few people with addictions, or their family members, testified before the Committee or submitted briefs.

With regard to addiction, self-help has had a pervasive presence with a long history — but within a culture of anonymity and independence, and with little government funding. This may explain why so few people with addictions, or their family members, testified before the Committee or submitted briefs.

> *Clean and Sober Thinking (CAST) is an unfunded addiction consumer organization based in Peel Region Ontario. CAST meetings provide support at a crucial time for an addict on the cusp of change. When someone in the soul destroying world of addictions decides to reach out, the fear is all-encompassing. The window of time in which a response is needed is brief and urgent. There is no comfort like that which is given by those who have been there — or in the case of a CAST meeting — those who are there. In Ontario, there is a whole*

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379 Rush, B. (undated) Concurrent mental and substance use disorders: Why is such "double trouble" so important? Submission to the Standing Senate Committee on Social Affairs, Science and Technology, p. 7.

culture of funded consumer initiatives for the mental health sector. There are no funded consumer initiatives for people with addictions. —Tom Reghr[380]

The testimony available to the Committee gave only a small glimpse into the pain caused by addiction.

I speak personally because my daughter, who has schizophrenia, is on crack. […] How can we expect a person with a serious mental illness whose cognitive abilities are affected, who has little or no motivation or insight, who lives a sort of hand-to-mouth existence every day, how can they ever manage to quit? The interventions, and resources and treatment facilities are hopelessly inadequate. The general attitude is to wait until they are ready to quit. Well, they do not want to quit. —Joan Nazif[381]

More people than we know are addicted to gambling — writing bad checks, lying, stealing, skipping work — all to feel the high of the instant gratification. But unlike other addictions, it is often hidden. There is no wavering gait, no slurred speech, no needle tracks. For three years, none of my friends knew I gambled. I went alone, and usually late at night. Playing the slots…at any cost, was my number one obsession. —Anonymous

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The pain pill addiction stripped me of my dignity and cost me a great deal. Aside from taking money from my family, I borrowed and stole the trust and faith they had in me. Nothing became as important as the high. I had to take more pills just to try and recapture the elusive feeling. The pills only exacerbated the struggles I was facing. I could finally see what had been only too clear to many others — my life was a mess. I was financially broke and my spirit was on overdraft. —Barry Strader[382]

The addiction field lacks powerful voices.

The addiction field lacks powerful voices, a vacuum that has left only policy makers and health providers to speak for anonymous clients. However good their advocacy, there is no substitute for direct testimony from people who are, or have been, "there." Individuals and families living with mental illness have successfully made the case to various provincial and territorial governments that the contributions of self-help organizations are so important that they must be funded. That this has not been done for addictions sets up inequality of representation between two groups, *both* of whom have crucial expertise to offer and important work to do.

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380 Reghr, T. (September 2005) Brief submitted to the Standing Senate Committee on Social Affairs, Science and Technology, p. 2.

381 6 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/18eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

382 Strader, B. (undated) Submission to the Standing Senate Committee on Social Affairs, Science and Technology.

Therefore, the Committee recommends:

40	**That a portion of the funding for peer support in the Mental Health Transition Fund (see Chapter 16) be made available to develop and sustain self-help and peer support groups for people and their families living with addiction (including problem gambling).**

9.3 FAMILIAR CULPRITS AND THE DAMAGE THEY CAUSE

While the production and trafficking of illicit drugs grabs headlines, legally available substances — alcohol[383] and prescription medication — have the greatest and most far-reaching impact on Canadians' lives and health, principally because of their pervasive presence and common usage.[384]

Legally available substances — alcohol and prescription medication — have the greatest and most far-reaching impact on Canadians' lives and health, principally because of their pervasive presence and common usage.

> *When you look at the idea of somebody who is addicted, you tend not to look at alcohol. If you do, it is a person sitting in an alleyway with a brown paper bag. You do not look at it as being the drinker inside the home; you do not look at prescription drugs and those kinds of things. The sensationalized reporting [on illicit drugs] does not help because what is in the news are the sensational stories, not the day-to-day lives of people. —Senator Cordy*[385]

Prenatal exposure to alcohol is now considered to be the *leading* cause of birth defects in North America. The magnitude of the problem of abuse of legal substances in Canada is often ignored because of stigma and denial. Nonetheless, the facts are clear:

Prenatal exposure to alcohol is now considered to be the *leading* cause of birth defects in North America.

- 13.6% of all Canadians are considered high-risk drinkers.[386]
- In any given year, it is estimated that 8% of all hospitalizations and 10% of the total number of days in hospital are attributable to substance abuse.[387]

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383 Tobacco is also a significant factor in negative health consequences.

384 Tim Stockwell, Michel Perron, Greg Purvis, and Jeff Wilbee, 21 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/28ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

385 21 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/28ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

386 Canadian Centre on Substance Abuse. (March 2005) Canadian Addiction Survey (CAS): A national survey of Canadians' use of alcohol and other drugs: Prevalence of use and related harms. Available at: www.ccsa.ca.

387 Single, E., Robson, L., Xiaodi, X., and Rehm, J. (1996) The costs of substance abuse in Canada. Available at: www.ccsa.ca.

- Prenatal exposure to alcohol is now considered to be the *leading* cause of birth defects in North America.[388]

- In 2000, a total of 981 people died in alcohol-related vehicle crashes in Canada (including pedestrians and off-road vehicles).[389]

- Canadians are among the highest per capita users of psychiatric medications in the world. Canadians are the second-highest users of sedatives and the fourth-highest of prescription narcotics.[390]

Canadians are among the highest per capita users of psychiatric medications in the world. Canadians are the second-highest users of sedatives and the fourth-highest of prescription narcotics.

- It is estimated that 20% of Canadians over 60 are long-term users of pain-killers.

- Women are 50% more likely to abuse medication than men. Aboriginal populations are particularly at risk for non-medical use of prescription medication.[391]

- Abuse of legal substances (including tobacco) accounts for $11.8 billion in annual productivity losses in Canada, or 1.7% of the gross national product (GNP), a cost that works out to $414 for every man, woman and child in Canada.[392]

Abuse of legal substances (including tobacco) accounts for $11.8 billion in annual productivity losses in Canada.

The reality is that the vast majority of Canadians who are addicted use legally available substances.

> *Ballpark, it would be 90 per cent of deaths caused by drugs are from alcohol and tobacco. If you look at disability and quality of life, it would probably be more like 95 per cent. The analysis done by the World Health Organization globally, including looking at economically developed countries such as Canada, shows this very clearly. —Tim Stockwell*[393]

The reality is that the vast majority of Canadians who are addicted use legally available substances. Many people are cross-addicted, meaning that they use alcohol and medication in a variety of combinations. Addiction is a health problem in which incidence can be affected by monitoring interventions (in relation to prescription drug use, for example,) and public awareness of the dangers.

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388 Health Canada, First Nations and Inuit Health Branch. (2004) Literature review: Evaluation strategies in Aboriginal substance abuse programs: A discussion. (2004) Available at: www.ccsa.ca.

389 Canada Safety Council. (2005) Alcohol-Crash Stats. Available at: www.safety-council.org/info/traffic/impaired/stats.html.

390 Rehm, J., and Weeks, J. (2005) Abuse of controlled prescription drugs. In Substance abuse in Canada: Current challenges and choices. Ottawa: Canadian Centre on Substance Abuse. Available at: www.ccsa.ca.

391 *Ibid.*

392 Canadian Centre on Substance Abuse, and Centre for Addiction and Mental Health. (1999) Canadian Profile 1999. Available at: www.ccsa.ca.

393 21 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/28ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

Therefore, the Committee recommends:

41	**That treatment resources targeted at addictions include addiction to legal substances such as alcohol, tobacco, and prescription medications, and to behaviors such as gambling.**

9.4 A NEW THREAT — PROBLEM GAMBLING

The prevalence of problem gambling has risen significantly over the past 25 years. In Ontario it is estimated that 3.8% of citizens (340,000 people) have moderate to difficult problems related to gambling; an additional 0.9% are severely addicted.[394] In 1999-2000, the net profit from gambling (after prizes and other expenses) to governments at all levels was $5.7 billion.[395] By 2004, that profit had risen to $6.2 billion, more than the net profit to government of tobacco and alcohol combined ($5.9 billion).[396]

Experts fear that most of the problems related to gambling remain hidden because of shame and stigma.

High school students gamble at two to four times the rate of the general public.

British Columbia, Manitoba, Quebec, Alberta, Ontario and Prince Edward Island have "responsible gaming" programs related to problem gambling. Ontario's commitment is 2% of gross revenues from slot machines in charitable casinos and at racetracks, the largest allocation to a problem gambling strategy anywhere in the world. In a recent review, however, it was found that the fund has not been fully disbursed (only $21.7 of the $36 million allocated was released in 2003-2004). Fewer (5,900) than the expected number of problem gamblers (8,600) sought treatment.[397]

Experts fear that most of the problems related to gambling remain hidden because of shame and stigma, but that they will emerge in due course and in overwhelming numbers. One indicator of what is to come is that high school students gamble at two to four times the rate of the general public — the problem gamblers of tomorrow.[398]

Canadian governments at all levels depend on revenues from gambling; it is likely that investment in gambling facilities will be increased. But the social, economic and health impacts for Canadians are just beginning to emerge and must not be ignored or minimized.

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394 Simpson, R. Brief submitted to the Standing Senate Committee on Social Affairs, Science and Technology.

395 Canada West Foundation. (2001) Gambling in Canada 2001: An Overview. Available at: www.cwf.ca.

396 Skinner, W. (September 2005) Submission to the Standing Senate Committee on Social Affairs, Science and Technology.

397 Sadinsky, S. (March 2005). Review of problem gambling and responsible gaming strategies of the Government of Ontario: A report to the Ontario Ministry of Health and Long-term Care and the Ministry of Economic and Trade Development. Available at: www.health.gov.on.ca/.

398 Youth Gambling International. (2004) Youth problem gambling. Available at: www.education.mcgill.ca.

Therefore, the Committee recommends:

42	**That provincial and territorial governments commit a fixed portion of funds derived from gambling to evidence-based prevention, awareness and treatment programs for gambling addiction, and to gambling addiction research.** **That Statistics Canada ensure that in addition to alcohol and drug use, the prevalence of problem gambling among the general population is measured and reported upon through regular survey work.**

9.5 THE MOST VULNERABLE

As with other health problems, people who are poor, marginalized or otherwise disadvantaged suffer disproportionately from addictions and/or problem gambling. Children and youth, women and seniors have particular vulnerabilities that may not be recognized and, as a result, are not addressed.

People who are poor, marginalized or otherwise disadvantaged suffer disproportionately from addictions and/or problem gambling. Children and youth, women and seniors have particular vulnerabilities.

9.5.1 First Nations, Inuit and Métis Peoples

As described in Chapter 14, Aboriginal people attribute their mental health and addiction problems to a history of colonization that assaulted their culture and created a pervasive atmosphere of despair.[399] Constant relocation of communities and the removal of children from families to residential schools disrupted traditional connections to family and community; whole generations were dislocated and traumatized. The effects are a weakened cultural identity, poverty, dependence on social welfare, and a profound sense of grief.[400]

First Nations, Inuit and Métis peoples suffer a host of health problems, not the least of which is addiction.

> *In Labrador alone, as the man was saying from the reserve, there have been an awful lot of suicides of young people. This is not limited to Labrador, but happens in St. John's and all over the province from depression. There are also*

399 Brant, C. (1993) Suicide in Canadian Aboriginal peoples: causes and prevention. In the Royal Commission on Aboriginal Peoples: The path to healing: Report on the national round table on Aboriginal health and social issues. Ottawa: Department of Supply and Services.

400 Mussell, B., Cardiff, K., and White, J. (2004) The mental health and well being of Aboriginal children and youth: Guidance for new approaches and services. Available at: www.mheccu.ubc.ca.

a lot of suicides in this province from those video lottery terminals and...from overdoses with drugs.... —Harold Dunne[401]

9.5.2 Women

Women differ from men in many respects, including their responses to substance use. For example, women are more likely than men to develop cirrhosis of the liver with less consumption of alcohol over shorter periods of time.[402] They are also more likely to be victims of domestic assault, child abuse and sexual violence; women who have suffered such experiences are more likely to develop substance abuse problems.[403] Because of the risk of birth defects, women of child-bearing years who are drinking or using drugs are of particular concern.

Because of the risk of birth defects, women of child-bearing years who are drinking or using drugs are of particular concern.

The system would benefit from more outreach services (educational seminars in places where high risk women gather naturally). These services not only help identify pregnant and parenting women but they are encouraged to begin treatment. Outreach is also critically needed for other populations like elderly women, youth, the chronic or severely addicted woman who is often homeless, and women offenders. These women frequently do not or cannot access services and we need to reach out to them with understanding and sensitivity. — Nancy Bradley[404]

9.5.3 Seniors

Up to 18% of hospitalized seniors are there because of alcohol abuse. Older adults use more prescription medication and, as a result, are particularly vulnerable to adverse drug reactions and interactions, and drug dependence.

Up to 18% of hospitalized seniors are there because of alcohol abuse.

In addition, problem gambling may be on the increase among seniors. An Ontario study found that 6.4% of seniors who gambled were at risk of addiction, with 0.1% already gambling at problem levels. A Manitoba study found 1.6% of seniors who gambled were at risk of addiction and 1.2% were already problem gamblers.[405] In all of Canada, there are only 12 specialized addiction treatment programs serving approximately 1,250 seniors annually.[406]

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401 14 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/22eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

402 American Liver Foundation. Cirrhosis: Many Causes. Available at: http://www.liverfoundation.org/db/articles/1059.

403 Bradley, N. (September 2005) Submission to the Standing Senate Committee on Social Affairs, Science and Technology.

404 *Ibid.*

405 Spencer, C. (June 2005) Alcohol and seniors: Gambling issues for seniors — Links, programs, research and resources. (June 2005) Available at: www.agingincanada.ca.

406 Spencer, C. (June 2005) Presentation to the Standing Senate Committee on Social Affairs, Science and Technology.

9.5.4 Children and Youth

Youth are most affected by mental health and addiction problems.[407] Research has shown that early evidence of substance abuse in children and youth is a predictor of subsequent criminal behaviour.[408] Some problem gamblers reported beginning to gamble as early as age 10.[409] Children and youth are also vulnerable to emotional, physical and sexual abuse by substance-using caregivers.[410]

Early evidence of substance abuse in children and youth is a predictor of subsequent criminal behaviour.

> *When it comes to early diagnosis…it is much easier to take care of the children before they get older. Early diagnosis…I know especially in addictions, can definitely save a life and a lifetime of heartache for not only the youth but so many others. —Dave Rodney*[411]

Failing to address the impact of addiction and problem gambling in vulnerable populations, particularly youth, costs Canada a great deal in both human and economic terms. In a "pay me now or pay me later" scenario, the neglect of these groups is paid out over time in ever-rising social and health care costs.

Failing to address the impact of addiction and problem gambling in vulnerable populations, particularly youth, costs Canada a great deal in both human and economic terms.

Therefore, the Committee recommends (in addition to those recommendations specific to Aboriginal peoples in Chapter 14):

43	**That the Government of Canada conduct an assessment of the outcomes of existing programs dedicated to addiction problems for First Nations, Inuit and Métis peoples.** **That the results of this assessment be shared through the Knowledge Exchange Centre to be created as part of the Canadian Mental Health Commission (see Chapter 16) with a view to identifying successful treatment models and expanding these programs to improve access and reduce wait times.**

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407 Statistics Canada. (2002) Canadian community health survey: Mental health and wellbeing. Available at: www.statcan.ca.

408 Dowden, C. (2003) The effectiveness of substance abuse treatment with young offenders. Available at: www.canada.justice.gc.ca.

409 Youth Gambling International. (2004) Youth problem gambling. Available at: www.education.mcgill.ca.

410 Trocme, N., et al. (2005) Canadian incidence study of reported child abuse and neglect 2003: Major findings. Available at: www.phac-aspc.gc.ca/.

411 9 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/21eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

That the provinces and territories develop and implement evidence-based outreach, and primary and secondary prevention programs for at-risk populations — women, children and youth, seniors, and those affected by Fetal Alcohol Spectrum Disorders.

9.6 GOVERNMENT RESPONSIBILITY

Addiction must also be considered within the context of government regulation and taxation related to the sale of alcohol and the prevalence of gambling (including provincial lotteries), both of which are significant revenue sources.[412] Powerful corporate interests are also involved in alcohol as well as gambling. Years of government inattention have left advocates frustrated by the low investment in prevention, health promotion and treatment for people who have been harmed, relative to the large amounts of money collected in taxes and gambling profits.[413]

Years of government inattention have left advocates frustrated by the low investment in prevention, health promotion and treatment for people who have been harmed, relative to the large amounts of money collected in taxes and gambling profits.

> *...we have to acknowledge the elephant in the room that no one seems to be tackling, which is that notwithstanding the need for looking at meaningful taxation processes for alcohol, volume content and the like, the government already collects a tremendous amount of revenue from this product and it is not earmarked for the right purposes. Although it may go to other good purposes, at the end of the day we should acknowledge openly that the government continues to encourage activities that they know will cause harm, such as gambling. —Michel Perron*[414]

9.7 NEW IDEAS THAT WORK

Notable strides have been made in helping people with addiction and mental health problems. These advances have been implemented in a number of locations in Canada and are showing either promising or positive results confirmed through research. They can be built upon to create a stronger, more integrated addiction and mental health system.

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412 In 2002-2003, sales of alcoholic beverages totalled $15.4 billion in Canada, with beer accounting for $12.6 billion. Taxes on alcohol and tobacco accounted for 2.5% of all tax revenue. Source: Thomas, G. (2004) Alcohol-related harms and control policy in Canada. Available at: www.ccsa.ca. In 1999-2001, net government revenue from gambling — across Canada — equalled $5.7 billion. Source: Canada West Foundation. (2001) Gambling in Canada 2001: Overview. Available at: www.cwf.ca. In 2001, the average Canadian household spent $257 on government lotteries alone. Source: www.cbc.ca/background/gambling.

413 Ontario Federation of Mental Health and Addiction Programs. (2003) Generating new revenue to support addictions services: A behavioural insurance model. Available at: www.ofcmhap.on.ca.

414 21 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/28ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

9.7.1 Integrated Treatment for Concurrent Disorders

Substance abuse can mask the symptoms of a mental illness but, for those who are known to be mentally ill, it makes psychiatric symptoms worse. As a result, people with concurrent disorders[415] generally have more complex problems and are more difficult to help because they often exhibit more disruptive behaviours, are less accepting of treatment and are more prone to relapse[416] than those whose mental illness is not compounded by addiction or vice versa.

Both the mental health and addiction "systems" have been slow to acknowledge even the existence of concurrent disorders. Typically, people with them cycle back and forth as clinician-specialists try to decide which problem to treat first.

Both the mental health and addiction "systems" have been slow to acknowledge even the existence of concurrent disorders.[417] Typically, people with them cycle back and forth as clinician-specialists try to decide which problem to treat first.

When concurrent disorders have been recognized, treatment has tended to fall into one of three categories: *partial* treatment — focusing on one of the problems, assuming the other will abate over time; *sequential* treatment — starting with one problem and resolving it before treating the other; or *parallel* treatment — where separate services treat both problems at the same time.[418] The results have been less than satisfactory, primarily because of the disconnect between the two treatment systems and their differing philosophies. People just got lost.

Literature calls for *integrated* treatment – both problems are treated simultaneously by the same team, using compatible techniques and philosophies.

Literature on best practices recommends that mental health and addiction programs screen clients for both problems and, when problems are discovered, those affected should be fully assessed to ensure their proper treatment. It also calls for *integrated* treatment – both problems are treated simultaneously[419] by the same team, using compatible techniques and philosophies.[420]

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415 The term *dual diagnosis* is used in the United Kingdom and the United States.

416 Stuart, H., on behalf of the Concurrent Disorders Champion Group. (2002) Concurrent disorders: An integrated service delivery plan for southeastern Ontario. (2002) Submitted to the Southeastern Ontario Mental Health Implementation Task Force and the Southeastern Ontario District Health Council.

417 Rush, B. (undated) Concurrent mental and substance use disorders: Why is such "double trouble" so important? Submission to the Standing Senate Committee on Social Affairs, Science and Technology.

418 Negrete, J. (2003) Treating addiction in individuals with other mental illnesses. Submission to the Standing Senate Committee on Social Affairs, Science and Technology.

419 The one exception is that best practice guidelines (Rush, 2002) call for substance abuse to be treated first among people with mood and anxiety disorders — although integrated treatment is recommended for Post-traumatic Stress Disorder.

420 Centre for Addiction and Mental Health. (2002) Best practices: concurrent mental health and substance abuse disorders. Available at: www.cds-sca.com.

9.7.2 Community Reinforcement and Family Training (CRAFT)

The CRAFT approach is an alternative to some of the more confrontational interventions or strong tactics used by frustrated family members to persuade a loved one to enter treatment. It is a teaching model, most often accompanied by a workbook, in which aspects of cognitive behavioural therapy are employed to help families and friends develop ways to keep themselves safe, analyze under what circumstances substance abuse is most likely to occur, utilize positive reinforcements for both themselves and the addicted family member, and adopt healthier lifestyles. Research has shown that this minimalist intervention is highly effective in engaging in treatment people with addictions, including problem gambling; a 64% success rate has been achieved for people with drug and alcohol problems, and seven out of ten problem gamblers have been brought to treatment.[421]

> *The more the family is involved, whoever they consider their family to be, the better they will do. —Nancy Bradley*[422]

9.7.3 Harm Reduction

Harm reduction is intended to reduce the health and social impact of alcohol and drug use without asking that users abstain. Abstinence may be a long-term objective, but the short-term goal is to promote safe use. The features of harm reduction are: *pragmatism* — people are going to use drugs and alcohol and some will use them to excess; *humane* values — the dignity and rights of the user are respected; *focus on harm* — it's not how much a person is using, it's how much harm it is creating; and *hierarchy of goals* — the most important needs are attended to first.[423]

Harm reduction is intended to reduce the health and social impact of alcohol and drug use without asking that users abstain. Abstinence may be a long-term objective, but the short-term goal is to promote safe use.

9.7.3.1 Needle Exchange Programs (NEPs)

In Canada, the first unofficial needle exchange program (NEP) opened in Toronto in 1987. More were established officially in Toronto and Vancouver in 1989. Today there are 30 programs operating in Canada. All prisons administered by Correctional Service Canada provide bleach to inmates for needle sterilization, but despite repeated recommendations for the implementation of NEPs, no correctional jurisdiction in Canada provides sterile equipment to inmates.[424]

No correctional jurisdiction in Canada provides sterile equipment to inmates.

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421 Ontario Problem Gambling Research Centre. (undated) Minimal treatment approaches for concerned significant others of problem gamblers. Available at: www.gamblingresearch.org/printdoc.sz?cid=123.

422 21 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/28ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

423 Thomas, G. (2005) Harm reduction policies and programs for persons involved in the criminal justice system. Canadian Centre on Substance Abuse. Available at www.ccsa.ca.

424 *Ibid.*

NEPs operate under an exemption in the Canadian *Criminal Code* and the *Food and Drugs Act* that makes the distribution of "drug paraphernalia" legal as long as the goal is to prevent HIV infection. Initially, the federal government shared the costs with provincial governments. Programs are now run under a variety of funding models, including federal and provincial/municipal partnerships. The cost of one needle exchange kit is slightly more than $1.

Many fears regarding these programs have been expressed but, according to the evidence, have not materialized:

- Needle exchange programs do not lead to a proliferation of dangerous needles discarded in the community — in fact, more needles are turned in than given out.
- Needle exchange programs have not attracted drug dealers to the community where the site is located.
- Police do not object — the Canadian Association of Chiefs of Police has passed a resolution in favour of the National AIDS Strategy, including needle exchange programs.[425]

9.7.3.2 Supervised Injection Facilities (SIFs)

Supervised injection facilities (SIFs) include needle exchange but also offer safe places to use drugs and receive emergency medical care, basic health services, counselling, and referrals to other agencies, plus education and participation in social support networks among others living with addictions. SIFs typically have a number of house rules that relate to safety — for example, no alcohol, no violence, no "dealing," local users only, and no one under 18 years of age.

The one SIF in Canada is in Vancouver. It functions as a scientific research project to be evaluated over three years. It was established under Section 56 of the *Controlled Drugs and Substances Act*, which allows the federal Minister of Health to issue an exemption from the provisions of the Act for specific medical or scientific purposes. Ninety percent of those who use the Vancouver SIF are Hepatitis C Virus positive, and 28-30% are HIV positive. Five hundred safe injections per day are provided at the site.[426]

9.7.3.3 Wine and Beer in Shelters

Some homeless people report that they will not enter shelters because they cannot bring their bottles with them; alternatively they binge just before entering, a cause of fights and injuries to staff and other residents. In

The program offers a glass of homemade wine once an hour, progressively diluted over time. Evaluation has shown fewer emergency room visits, hospitalizations and ambulance calls as a result.

425 Canadian Centre on Substance Abuse. (February 2004) Needle Exchange Programs (NEPs): FAQs. Available at: www.ccsa.ca.

426 Canadian Centre on Substance Abuse. (July 2004) Supervised injection facilities (SIF): FAQs. Available at: www.ccsa.ca.

response to violence in shelters and deaths on the street by freezing, staff in a few Toronto locations have started to introduce an approach to harm reduction that entails giving those living with alcohol addiction a drink of beer or wine every hour or two during their stay.

The Annex Harm Reduction Program, a satellite of St. Michael's Hospital in Toronto serving the men who live in Seaton House,[427] now offers medical treatment and referrals to addiction treatment and housing. The preliminary results of an evaluation show that alcohol-related accidents and injuries are declining, that the men now drink safer forms of alcohol (instead of Lysol, mouthwash or rubbing alcohol), and that they receive better medical care. Some have reduced their drinking; others have entered treatment, while still others are in stable housing and have jobs.[428]

In Ottawa, the Shepherds of Good Hope Shelter has established a harm reduction program with a Supporting Community Partnerships Initiatives (SCPI) grant. It serves 10 people at a time, 24 hours a day, seven days a week and has a waiting list three times as long. The program offers a glass of homemade wine once an hour, progressively diluted over time. Evaluation has shown fewer emergency room visits, hospitalizations and ambulance calls as a result. Graduates of the program have obtained stable housing, stayed out of jail and entered treatment for addiction.[429]

9.7.4 Drug Treatment Court (DTC)

In 1998, the federal Department of Justice funded one drug treatment court (DTC) in Toronto and another in 2001 in Vancouver. These courts identify low-risk offenders whose main problem is drug abuse and who would benefit from treatment rather than time in jail. Offenders, including youth, are offered drug education, employment training and mental health treatment if they openly take responsibility for the offences they have committed. Sentencing is often confined to community service hours; alternatively, charges may be withdrawn if treatment is completed in a positive fashion. In May 2003, the federal government committed $23 million over five years to expand DTCs.[430]

9.7.5 Day Detox and Home-Based Detox

The most cost-effective strategy for responding to early-stage alcohol problems is a single session of advice from a primary care physician with follow-up by a nurse.[431] Advances in research relating to detoxification services have shown also that people with physiological dependence on alcohol or drugs can enter a successful detox program that offers them

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427 Seaton House is a shelter serving men.

428 Wysong, P. (November 2002) Homecare for the homeless. Medical Post, Vol. 38, Issue 40. Available at: www.medicalpost.com.

429 Alderson-Gill & Associates Consulting Inc. (2002) Evaluation prepared for the National Homelessness Initiative: Shepherds of Good Hope, Harm Reduction Program, Ottawa, Ontario. Available at: www.homelessness.gc.ca/projects/casestudies/docs/ottawa/shepherds_e.pdf.

430 Citizens for Mental Health Association. (2003) Backgrounder: Justice and Mental Health. Available at: www.cmha.ca/citzens/justice.pdf.

431 Stockwell, T., assisted by Sturge, J. (September 2005) Brief to the Standing Senate Committee on Social Affairs, Science and Technology.

nursing support in their own homes or on a day program basis.[432] The idea of Community Alcohol Teams was developed in the United Kingdom and elsewhere because of long waiting lists for inpatient beds. Studies of the relative costs showed that hospital-based care cost roughly 10 times more than community care with little difference in outcomes.[433] It should be noted, however, that homeless populations still require some form of residential detox service.

> *One example in the service I provided in the U.K is that we had one community nurse supervising as many home-based detoxifications for problem drinkers as the general hospital, which had been the other major service provider in the area, did in one year. —Tim Stockwell*[434]

With the exception of the treatment of concurrent disorders and the CRAFT program, the emerging trends in this section remain controversial, particularly those related to harm reduction. Society judges harshly those it thinks have made bad choices. Harm reduction challenges perceptions because it is an adult-to-adult model that focuses on keeping everyone, including society as a whole, as safe as possible while preserving dignity and hope for those affected.

The most cost-effective strategy for responding to early-stage alcohol problems is a single session of advice from a primary care physician with follow-up by a nurse, nursing support in their own homes or on a day program basis

Given these advances, the Committee recommends:

44	**That the Government of Canada include as part of the Mental Health Transition Fund (see Chapter 16) $50 million per year to be provided to the provinces and territories for outreach, treatment, prevention programs and services to people living with concurrent disorders.** **That family physicians be trained, through medical school and professional development curricula, on diagnostic guidelines for Fetal Alcohol Spectrum Disorders (FASD).** **That family physicians be trained in the use of brief intervention and interview techniques to recognize problem substance use leading to addiction.**

[432] Brunemeyer, N. (March 2004) Addictions services redesign at Vancouver Coastal Health. Four Pillars News, Vol. II, Issue 1. Available at: www.city.vancouver.bc.ca/fourpillars/newsletter.

[433] Hayashida, M., Altman, A., McLellan, A., O'Brien, C., Purtil, J., Volpicelli, J., Pahelson, A., and Hall, C. (1989) Comparative effectiveness of inpatient and outpatient detoxification of patients with mild-to-moderate alcohol withdrawal symptoms. New England Journal of Medicine, Vol. 320, No. 6, pp. 358-365.

[434] 21 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/28ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

9.8 STEPS TO INTEGRATION

9.8.1 Build on Commonalities

Historically, mental health and addiction services have developed separately — each with its single focus. Addiction and mental illness are both enormously complex problems. Services for each must address a multiplicity of factors and contend with a host of personal and social consequences. Outcomes are uncertain even when the best of supports and treatments are in place. The two sets of services rest on differing philosophies relating to causes, effects and how to help. But there are signs of convergence, not the least of which are the emergence of literature on best practices and treatment of concurrent disorders, and the establishment of some joint services.

> *In my experience over the past 13 years, I have found that the "my turf" attitude has diminished to some degree. I have talked to people in the community who have said that there might be battles at the provincial level, but at the community level, everyone gets along fairly well. —Jeff Wilbee*[435]

9.8.1.1 Recovery

Recovery has been a beacon of hope since the 1935 inception of the most famous self-help movement, Alcoholics Anonymous. Recovery is well defined in the addiction world — as a lifelong process of living well in the face of challenges. In the last 20 years, led by people living with mental illness, the mental health system has begun to embrace recovery[436] as its defining concept. That concept, however, has yet to fully inform professional treatment philosophies.

9.8.1.2 Self-Help and Peer Support

Although founded on self-help, addiction services have been professionalized over time. Substance abuse specializations have developed in higher learning centres, together with professional accreditation and certification. Most addiction services now have strong professional leadership. The modern mental health system began with a medical specialty, psychiatry, that, over the last century, has spawned a number of other mental health professions such as psychiatric nurses and social workers. Relatively speaking, the self-help movement in mental health is new and has had to advocate strongly for its place in the largely professionally driven system. Happily, providers in both addiction and mental health services have

Recovery is well defined in the addiction world — as a lifelong process of living well in the face of challenges. In the last 20 years, led by people living with mental illness, the mental health system has begun to embrace recovery as its defining concept.

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435 21 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/28ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

436 See Chapter 3 for a fuller discussion of how "recovery" is defined within the mental health system.

come to understand and value self-help and peer support, while still acknowledging the need for a professional presence.

> *We still have peer professionals, and I do not think anyone can provide a sense of hope for change for a consumer group better than people who [have] gone through the system themselves. I do not think anyone can navigate or advocate better. There will always be a place for that, but the ratio is changing [peer support versus professional care] because of the type of service we are delivering.*
> *—Greg Purvis*[437]

9.8.1.3 Non-Medical Community-Based Services

Addiction services, evolving out of self-help, have a historical commitment to a community-based, non-medical approach. While individuals must, from time to time, seek medical interventions and/or psychiatric assessment, diagnosis and medication, it may be said that, as a whole, services for people with addictions are intent upon remaining non-medical in nature and community-based.

Addiction services, evolving out of self-help, have a historical commitment to a community-based, non-medical approach.

Community mental health services evolved as a result of the deinstitutionalization that began in the late 1960s.

Community mental health services evolved as a result of the deinstitutionalization that began in the late 1960s. Throughout Canada, governments have continued to close psychiatric inpatient beds. Although investment in community services has been too slow to materialize, the commitment from policy makers and from the field to building a system based mainly on non-medical community supports and services is solid.

9.8.1.4 Broader Determinants of Health

Community mental health services evolved as a result of the deinstitutionalization that began in the late 1960s.Managers and providers of mental health and addiction services are deeply aware of the importance of broader health determinants in preventing problems in the first place, and/or in lessening the effects of problems once they emerge. Safe and affordable housing, employment, education, adequate income supports, and freedom from violence are crucial to the health and well-being of all Canadians; they are life-sustaining for people living with mental illness and addiction.

9.8.1.5 Early Intervention

Identifying problems early, and then intervening in the least disruptive and life-altering manner possible, is acknowledged by both service sectors as crucial. Healthy pregnancies, assisting at-risk parents to acquire skills, a focus on early childhood development, and helping

Early intervention in psychosis is perhaps the most hopeful integrative treatment approach to emerge in mental health.

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437 21 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/28ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

children and youth with emerging substance abuse problems, all save lives and/or prevent a lifetime of dependence on a variety of expensive health and social programs.

Early intervention in psychosis is perhaps the most hopeful integrative treatment approach to emerge in mental health. Young people at risk, identified early and given lower doses of medication over shorter periods of time, can avoid hospitalization, loss of education, unemployment, and the loss of social and family supports.

> *Senator, you asked about pieces that are missing. What struck me immediately was the number of times I have read and heard presentations at conferences about childhood trauma, abuse and addiction. What I am about to say is not just about how to improve the treatment system but how to decrease the demand for the treatment system. An increased effort to deal with damaged children will have as much impact on the addiction treatment system as anything done directly in the addiction treatment system. —Jon Kelly*[438]

Competition between the addiction and mental health care sectors for scarce resources makes no sense. It only entrenches differences and discourages collaboration. However, there is reason to believe that numerous commonalities have emerged over time. It is now time for addiction and mental health services to begin to build integrative mechanisms based upon their shared interests, views and, above all, the benefits to affected people that will accrue.

Competition between the addiction and mental health care sectors for scarce resources makes no sense. It only entrenches differences and discourages collaboration.

9.8.2 A Step-by-step Approach

British Columbia's policy document entitled *Every Door is the Right Door* proposes to develop a collaborative model of health system responses that spans the domains of population health, health promotion, harm reduction and building community capacity. The model is intended to assist local health authorities to plan, implement and evaluate an integrated and evidence-based system for people with addictions and mental illness.[439]

British Columbia's policy document entitled *Every Door is the Right Door* proposes to develop a collaborative model of health system responses that spans the domains of population health, health promotion, harm reduction and building community capacity.

Alberta's document, *Building capacity: A framework for serving Albertans affected by addiction and mental health issues*, aims to improve access and services for people with concurrent disorders through service partnerships and shared care, typically psychiatrists providing consultation to

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438 21 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/28ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

439 British Columbia Ministry of Health Services. (May 2004) Every door is the right door: A British Columbia planning framework to address problematic substance use and addiction. Available at: http://www.healthservices.gov.bc.ca/mhd/pdf/framework_for_substance_use_and_addiction.pdf.

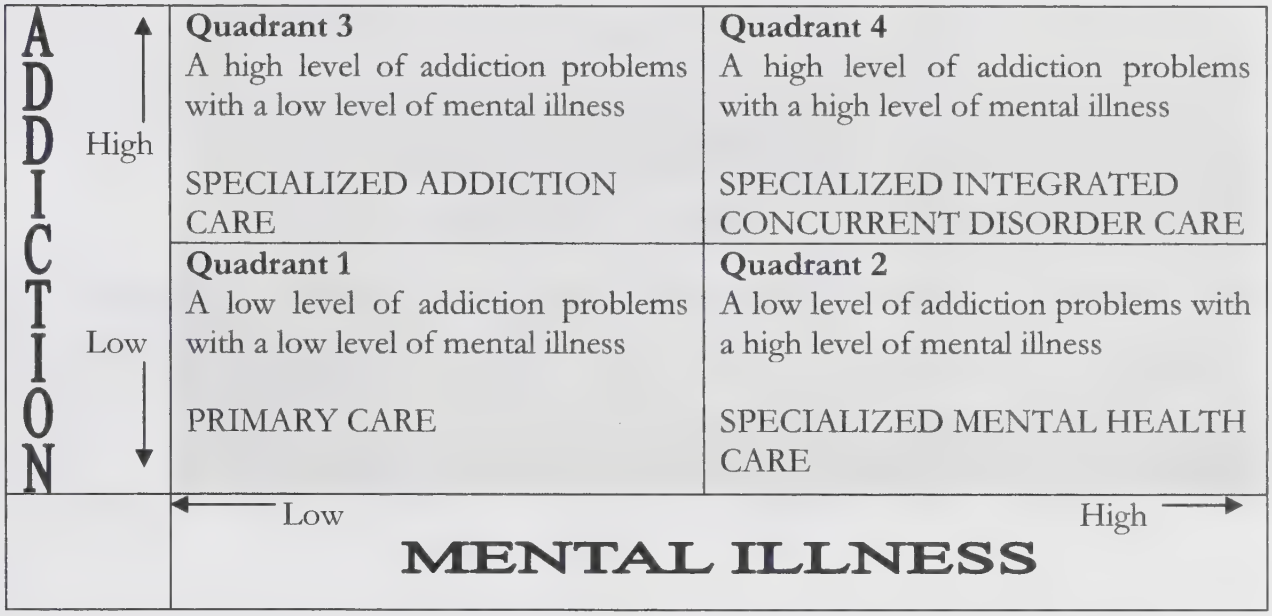
primary care physicians. The framework also emphasizes information, prevention and early intervention for those whose conditions are not yet severe.[440]

> *[The CCSA] position is quite clear. We fully support a new model for the coordinated delivery of mental health and addiction services to Canadians, and we believe that where appropriate, such a model requires a careful and strategic integration of approaches to treatment of mental health problems and addictions. —Michel Perron*[441]

Alberta's document, *Building capacity: A framework for serving Albertans affected by addiction and mental health issues*, aims to improve access and services for people with concurrent disorders through service partnerships and shared care, typically psychiatrists providing consultation to primary care physicians.

9.8.2.1 The Quadrant Model

This model is well-known among service providers in the addiction field. It has been endorsed as a "thinking tool" that helps conceptualize integration in a way that respects the differences between the mental health and addiction fields while, at the same time, offering opportunities for integration that can be acted upon fairly swiftly.[442]



People with a combination of a low level of mental health and addiction problems (Quadrant 1) are by far the largest segment of society who will seek help most frequently from a primary care physician. The quadrant model proposes that addiction and mental health services become *concurrent disorder capable*, meaning that those services must be able to

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440 Alberta Alcohol and Drug Abuse Commission. (July 2005) Building capacity: A framework for serving Albertans affected by addiction and mental health issues. Available at: www.aadac.com.

441 21 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/28ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

442 Skinner, W. (September 2005) Submission to the Standing Senate Committee on Social Affairs, Science and Technology.

recognize and respond to both mental health and addiction problems. Only those who fall into Quadrant 4, the number of whom is not large, require *concurrent disorder specialized services.*

The quadrant model does not value one service system over another. Nor does it presuppose the amalgamation of administration and services over the two fields, or the elimination of specialized programs. Integrative mechanisms could be built locally to include: service agreements among mental health and addiction agencies; designation of local "lead" organizations that take on the role of intake, assessment and referral; communication tools that facilitate the secure exchange of personal health information; and the use of distance technology to bring mental health, addiction and specialized services to remote or under-serviced areas.

9.8.2.2 A Shared National Focus

The addiction field has had the benefit of a National Drug Strategy (May 2003), a national survey of Canadians' use of alcohol and drugs (the *Canadian Addiction Survey*, November 2004) and the ongoing leadership of the Canadian Centre on Substance Abuse. A National Framework for Action on Substance Use and Abuse is currently being created through a broad consultation process culminating in a national addiction conference held in June 2005.[443]

On 7 June 2005, the House of Commons passed a motion calling for, among other things, a national strategy on mental health.[444] This motion paves the way for the creation of a National Mental Health, Mental Illness and Addiction Strategy which must incorporate, but not subsume, ongoing national activities in the field of addiction.

9.8.2.3 Taking the Long View

The experience in other jurisdictions where integration has begun shows that it is a difficult process despite the commitment of people in the field. Creating a closer relationship between the addiction and mental health systems will take time, leadership and money, but the first steps must be taken without delay.

The preferred approach to integration is to preserve that which is unique in each field, while building on common values, dialogues and obvious points of agreement.

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443 The National Framework has identified: Issues (increasing awareness of problematic substance abuse, reducing the problematic use of alcohol, preventing the problematic use of pharmaceuticals, addressing enforcement strategies and addressing Fetal Alcohol Spectrum Disorder); Supportive Infrastructure (sustaining workforce development, increasing access to services, implementing a national research agenda along with knowledge transfer, and modernizing legislation, regulatory and policy frameworks); and Key Populations (children and youth, people of the North, First Nations, Inuit and Métis, and offenders).

444 The motion reads as follows: "That, given a national strategy is needed now to reduce the growing human and economic costs of cancer, heart disease and mental illness; the House call on the government to fully fund and implement the Canadian Strategy for Cancer Control in collaboration with the provinces and all stakeholders, and given that Canada is one of the few developed countries without a national action plan for effectively addressing mental illness and heart disease, the government should immediately develop and initiate a comprehensive national strategy on mental illness, mental health and heart disease" [emphasis added].

> *If people have the freedom to talk, discuss and disagree on the process and work their way through it, then that will breed far more grassroots buy-in. [...] Once the awareness-raising happens, and people begin to get their heads around it, we will need resources and opportunities for them. Without those, it would be much ado about nothing. The resources must be available in your back pocket before you step forward into consciousness-raising. Otherwise, you are setting people up to disagree, and for it not to happen. Also, you need to build in outcomes, measure the outcomes, and feed them back to the field. Nothing will increase the buy-in more in the field of mental health and addictions for a change in process than positive outcomes. People want to succeed and do well by their clients. —Greg Purvis*[445]

Addiction services in Canada are fragmented and chronically under funded, resulting in inadequate responses to the needs of those living with addiction and their families. The culture of separateness between mental health and addiction services has added to the frustration. But a number of important commonalities can be utilized as logical starting points for integration. Committee members were told that the preferred approach to integration is to preserve that which is unique in each field, while building on common values, dialogues and obvious points of agreement.

Therefore, the Committee recommends:

45	**That the Canadian Mental Health Commission (see Chapter 16) actively partner with national addiction organizations, and work toward the eventual goal of integration of the addiction and mental health sectors.**

9.9 CONCLUSION

Advances in scientific knowledge have produced interventions that show positive results for people with addictions. The Committee's witnesses emphasized particularly the need for integrated treatment for people with both mental health and addiction problems — concurrent disorders. We support this direction.

The Committee's witnesses emphasized particularly the need for integrated treatment for people with both mental health and addiction problems — concurrent disorders.

We call for sustained investment to mitigate the effects of the misuse of legal substances on the health and well-being of Canadians.

Testimony was notably absent from people living with addictions, and from their families. The Committee commends for their courage those who did step forward. We are committed to building a strong consumer and family presence within the addiction sector.

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445 21 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/28ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

Testimony before the Committee made overwhelmingly clear the problems associated with addictions to legally available substances coupled with long waits for help. We call for sustained investment to mitigate the effects of the misuse of legal substances on the health and well-being of Canadians.

Gambling is a significant revenue source for governments, but many people are gambling at problem levels and are not seeking treatment in the numbers expected. This hidden problem is only beginning to emerge; it must not be ignored, nor must its lack of visibility lead to a false sense of complacency. Governments must help those who are harmed by gambling.

Governments must help those who are harmed by gambling.

The Committee was persuaded by arguments in favour of harm reduction.

The Committee was persuaded by arguments in favour of harm reduction. These varied approaches, which have been demonstrated to relieve suffering, have often been developed by direct services workers who use their ingenuity to solve the problems they and their clients face daily.

The Committee calls for effective outreach and prevention strategies focused specifically on those who are most at risk.

Vulnerable populations — Aboriginal peoples, youth, seniors and women — suffer disproportionately from the effects of addiction and problem gambling. We were particularly affected by the preventable tragedy of Fetal Alcohol Spectrum Disorders. The Committee calls for effective outreach and prevention strategies focused specifically on those who are most at risk.

The Committee was impressed with the level of agreement among witnesses in support of the eventual integration of the mental health and addiction sectors. We heard that the differences and debates that can preoccupy service providers and policy makers do not make much sense to people with addictions and their families. All they want is help — now. Fortunately, the Committee heard that there are many points of agreement between addiction and mental health services that can be built upon as integrative mechanisms.

CHAPTER 10:
SELF-HELP AND PEER SUPPORT

10.1 INTRODUCTION

> *Self-help provides emotional support and practical help. It is the kind of help you cannot duplicate in a doctor's office. No one can say better than somebody living with, through and beyond a mental illness, "I understand how you feel. I am on a quest for recovery with you." —Linda Bayers*[446]

People and families living with mental illness are turning more and more to self-help and peer support as a substitute for, or as an adjunct to, hospital, community and professional services.

Over the course of its extensive public hearings, the Committee heard regularly from people living with mental illness or addiction, and their families, who are disappointed by their lack of access to services and disheartened by the paucity of hope that they feel characterizes mental health and addiction care in Canada. While acknowledging that professional help is valuable, people and families living with mental illness are turning more and more to self-help and peer support as a substitute for, or as an adjunct to, hospital, community and professional services.

The best-known self-help program is Alcoholics Anonymous (AA), which began operation in 1935. Only a few years later (1937), Abraham Low, a physician, founded Recovery Inc., focused specifically on the needs of people with mental illness, headquartered in Chicago. Today, it maintains its strictly volunteer tradition all over North America (www.recovery-inc.org). Similarly, GROW, founded in Sydney, Australia, in 1957, supports thousands of members based on its version of a 12-step program and a philosophy of "caring friendship and mutual help" (www.grow.net.au).

In Canada, the first alternative mental health service based on people living with mental illness helping one another, called the Vancouver Mental Patients' Association (MPA), was established in 1971. It remains in operation (now calling itself Motivation, Power and Achievement - MPA) (www.vmpa.org).

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446 10 May 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/15evc-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

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National Peer Support Program for current and former Canadian Forces Members (www.ossis.ca). This unique program, launched in February 2002, is part of the Operational Stress Injury Social Support Project. It has served 1400 individuals and family members since opening, with referrals coming at a pace of one per day. Across 12 sites, it employs 20 trained Peer Support Workers, each of whom has experienced a stress injury. A professional team is available for consultation if required. Family members have six sites across the country. The role of the Peer Support Workers is two-fold: To help others heal from an operational stress injury and to pay attention to their own self-care. This non-medical model has been presented to audiences in Canada, Australia and Berlin. The program's goal is "to provide the best possible peer support to the men and women of the Canadian Forces, who continue to participate in an ever-growing number of demanding operations around the world" (General Ray Henault, Chief of Defence Staff, 2002). Says Lt. Colonel Stéphane Grenier, Project Director, "Peer support saves lives everyday."

10.2 THE MOTIVATIONS BEHIND SELF-HELP AND PEER SUPPORT

People living with mental illness, and their families, point to the many negative messages from society and from professional caregivers that impede healing and recovery.

> *In today's society, the stigma of mental illness plagues us still. We feel this stigma everyday of our lives… from being overlooked for promotion at work... to being harassed by medical insurance companies who question the validity of our illnesses so they no longer have to pay disability benefits… to sitting in emergency waiting rooms for hours on end, sometimes leaving in despair… because we are not high priorities.*
> *—Frank Dyck*[447]

10.2.1 Finding a Place to Belong

People living with mental illness say that the most devastating impact on their lives came not from the illness itself but from the way others began to treat them. Prejudice and discrimination take many forms: disregard for the person's rights, ostracism, loss of friends, sometimes rejection by family members and, in many instances, loss of housing and employment. Thirty-four percent of respondents participating in the Committee's e-consultation reported that they or others they knew had been turned down for a job or fired because of a mental illness, and 21% had been denied housing by a landlord.[448]

People living with mental illness say that the most devastating impact on their lives came not from the illness itself but from the way others began to treat them.

[447] Dyck, F. (2 June 2005) Speaking notes prepared for hearings of the Standing Senate Committee on Social Affairs, Science and Technology.

[448] Chodos, H., N. Pogue and T. Riordan. (2005) E-consultation on mental health, mental illness and addiction: Phase one. Parliamentary Information and Research Service, Library of Parliament.

We know when we break a leg we go to the emergency room. But if we are having a panic attack or thinking of harming ourselves, we don't know where we should go. We are told to go to the emergency room, but they see no wounds and we are dismissed. —Anonymous

Families also bear the brunt of stigma.

Families also bear the brunt of stigma. Making matters worse, people and families living with mental illness may internalize these negative social attitudes and blame themselves for their own marginalization. People living with mental illness state that there is also "prejudice and discrimination in the mental health system itself" — the system to which they turn for help when they are most vulnerable.[449]

Two-thirds of people suffering from addiction or mental illness simply do not seek help.

Twenty-two percent of respondents to the Committee's e-consultation reported that they had been treated with disrespect by medical personnel or had a physical ailment ignored because of their mental illness or addiction.[450] Not surprisingly, research shows that two-thirds of people suffering from addiction or mental illness simply do not seek help.[451]

Self-help and peer support counteract stigma by providing people a place where they are safe and welcome.

Self-help and peer support counteract stigma by providing people a place where they are safe and welcome. This is particularly important for client groups that have been poorly served by the mainstream mental health system:

Over time, it became clear that it might not be possible, and perhaps not even desirable, to promote cultural sensitivity within the conventional mental health service providers, with a view to these agencies at some point undertaking the responsibility to deliver this type of healing alternative. [...] [Healing circles] are rooted in ceremonies and traditions that can only be performed by those from the Aboriginal community who possess a depth of knowledge and who are recognized within that community as being capable of leading healing circles.

[...]

Over the life of the project... the majority [of clients] use the healing circles alone as their preferred method of recovery. —Tarry Hewitt[452]

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449 Standing Senate Committee on Social Affairs, Science and Technology. (November 2004) Report 1 — Mental health, mental illness and addiction: Overview of policies and programs in Canada, Chapter 3, Section 3.4.1, p. 59 (Quote from Jennifer Chambers' testimony).

450 Chodos, H., N. Pogue and T. Riordan. (2005) E-consultation on mental health, mental illness and addiction: Phase one. Parliamentary Information and Research Service, Library of Parliament.

451 Standing Senate Committee on Social Affairs, Science and Technology. (November 2004) Report 1 — Mental health, mental illness and addiction: Overview of policies and programs in Canada, Chapter 3, Section 3.2.1, p. 42 (Quote from Rena Scheffer's testimony).

452 16 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/22evc-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

10.2.2 Counteracting the Powerlessness of the Patient/Client Role

The Committee was told that playing the role of patient or client is debilitating in itself because the focus is on illness and disability.[453] Being dependent on help from those who claim exclusive expertise and who, by definition, are in a superior position, further erodes the self-esteem of the person who is defined as the patient or client as well as their ability to act effectively in their own interests. Over time, people can lose hope and fully embrace passivity. Experience has taught them that their views are unwelcome, someone else knows better, and it is easier (and in some instances, safer) to cease to struggle and let others make decisions.

> *It is very hard to ignore [professional] feedback or to put it aside as just one person's opinion when it comes from a health professional, and it is really hard to stand up in the face of authority and say, "I want more,"...particularly because you are a mental patient... —Helen Hook*[454]

10.2.3 Finding Hope in a Sea of Hopelessness

People living with mental illness have often been told that they will not complete their education and will never hold a job or work. For many years, researchers characterized mental illness as generating an inevitable downward spiral — both in function and in social status. The prognosis was bleak: permanent disability, isolation and poverty.

The opinions of people living with mental illness have too often been reinterpreted as a manifestation of denial or as "part of the illness," disallowing them a credible role in their own care and life decisions.

People living with mental illness state that their expression of healthy human emotions such as sadness, fear and anger is often medicated as opposed to validated.

The opinions of people living with mental illness have too often been reinterpreted as a manifestation of denial or as "part of the illness," disallowing them a credible role in their own care and life decisions. Pejorative labels such as non-compliant, manipulative, difficult to direct, hard to serve, attention-seeking or interfering (for family members) have discredited assertive behaviours and have further silenced people.

People living with mental illness state that their expression of healthy human emotions such as sadness, fear and anger is often medicated as opposed to validated.[455] The elements of human growth and pleasure are transformed into therapeutic interventions, such as bibliotherapy, art therapy, music therapy, horticultural therapy, interpersonal relationship therapy, and social network therapy, etc. These interventions may be helpful but they constitute professionally mediated encounters that recast normal activities in terms of treatments.

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453 Mead, S., D. Hilton, and L. Curtis. (Undated) Peer support: A theoretical perspective. Available at: www.mentalhealthpeers.com.

454 15 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/05eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

455 Everett, B. (2000) Consumers and psychiatric survivors confront the power of the mental health system. Waterloo, ON: Wilfrid Laurier University Press.

The range of supports that currently exist for those who are deemed unable to work includes a monthly pension with subsidized medications, subsidized housing for the fortunate, and a support network of health professionals and programs for free. I would suggest that many individuals are trapped and left unmotivated to plan and execute an exit strategy from this cycle of learned helplessness. —Raymond Cheng[456]

10.2.4 An Antidote for Identity Theft

Persons living with mental illness are asked to accept their diagnosis as reality and to develop insight into their illness and disability, so much so that they feel their identities as parents, siblings, employees, students, athletes, artists — as individuals — are erased or, at the least, diminished. People are spoken of as addicts, schizophrenics or depressives. They have *become* their illness.[457]

People are spoken of as addicts, schizophrenics or depressives. They have *become* their illness.

Some argue that their personhood has been invaded, conquered and colonized in much the same way countries have been defeated and occupied by a foreign power.

10.2.5 Reclaiming One's Own Story

People and families living with mental illness often have to tell their stories over and over again to a variety of disconnected professionals.[458] Even more problematic is loss of control over their own histories. Many feel that reinterpretation of their experiences in the unfamiliar language of medical or rehabilitation terminology does not describe adequately the personal reality of that experience. These "translations" can overlook the context of their lives, concentrating on their conditions rather than acknowledging what is wrong with their individual situations.[459] Experiences of abuse, racism, oppression, marginalization, homophobia, sexism, childhood trauma, violence in relationships, loss and grief, poverty, bullying, unemployment and other stressful life circumstances can be ignored or, if included in the "translation," fail to lead on to interventions that take them into account. Positive factors such as a supportive family, a particular talent, or dedication to culture and community can also be missed when the "translator" concentrates narrowly on assessment, diagnosis and medication.

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456 17 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/07ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

457 Estroff, S. (1989) Self, identity and subjective experiences of schizophrenia: In search of a subject. Schizophrenia Bulletin, Vol. 15, No. 2, 189-196.

458 Standing Senate Committee on Social Affairs, Science and Technology. (November 2004) Report 1 — Mental health, mental illness and addiction: Overview of policies and programs in Canada, Chapter 1, Section 1.1.1, p. 8 (Quote from Loise Forest's testimony).

459 Mead, S., and C. MacNeil. (2004) Peer Support: What makes it unique? Available at: www.mentahealthpeers.com.

In the course of my work, I hear stories of abuse, abuse perceived in the eyes of patients and I feel the force of their outrage at how they have been treated.
—Ron Carten[460]

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The Dream Team (Toronto) (www.thedreamteam.ca). The team is made up of persons living with mental illness, and their families, who distilled their personal stories into three-minute speeches delivered to politicians, community groups, universities and anyone who will listen to their message — safe, affordable housing saves lives. The group books presentations for a fee and its goal, aside from getting the central message across in an entertaining and moving way, is to validate consumers' and families' life stories.

10.2.6 Meeting the Need for Information

Accurate and complete health and service information is essential to the role of full partner in one's own care or that of a loved one. People living with mental illness, and their families, have told the Committee that they lack access to even the most basic information. For example, 33% of respondents to the Committee's e-consultation said services could be improved simply if more information was made available.[461] Sixty-six percent of families identified information as a pressing need.

People living with mental illness, and their families, have told the Committee that they lack access to even the most basic information.

People and families living with mental illness believe there is no substitute for conversations with a peer and exchanges of information among those who have "been there."

What does a diagnosis of mental illness mean? What will the medications do? Where can I get community services? How do I get help for a loved one with an addiction? What are my rights?

Rushed professionals may offer few answers or communicate in a way that is hard to understand. As a result, people and families living with mental illness believe there is no substitute for conversations with a peer and exchanges of information among those who have "been there."

> *...if you have a health problem, go to a self-help group. You will find out information because self-help group members are information junkies surfing the Internet day and night for information on how to get better and how to recover. They provide emotional support and practical help. They are cheerleaders. They say, "You can do it because I did it." Where else can you*

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460 Carten, R. (June 2006) Submission to the Standing Senate Committee on Social Affairs, Science and Technology.

461 Chodos, H., N. Pogue and T. Riordan. (2005) E-consultation on mental health, mental illness and addiction: Phase one. Parliamentary Information and Research Service, Library of Parliament.

do that when you are feeling hopeless? There is no place else on planet earth where you can get that kind of help. —Linda Bayers[462]

The Committee recommends:

46	**That programs be put in place to develop leadership capacity among persons living with mental illness, and their families.** **That the Knowledge Exchange Centre (see Chapter 16) contribute to building this capacity by facilitating electronic access to information and technical assistance for people affected by mental illness and their families.**

10.2.7 Having a Voice

People with experience of the mental health system frequently report that they are the voice least heard, both as individuals and at the systems level. Advocacy means "to give voice to." That is the fundamental purpose of a number of self-help organizations speaking on behalf of people who are or have been in the mental health or addiction system. Having a say in matters that most affect you is essential to everyone's sense of well being and citizenship. Groups that are entirely made up of the people for which they speak are uniquely empowering. They constitute a vital resource for communities that typically are talked about but seldom talked to.

10.2.8 Finding Recovery

Self-help and peer support groups are the incubators of individual recovery and a key sustaining force behind the broader acceptance of recovery as the guiding principle for all that occurs in the formal system.

The hopeful and optimistic concept of recovery[463] has emerged from the consumer movement and in response to negative treatment experiences in the formal mental health and addiction system. Utilizing experiential knowledge hard won through their own struggles, people living with mental illness have initiated a new dialogue that has begun to influence government policy and is slowly making its way into professional literature. Self-help and peer support groups are the incubators of individual recovery and a key sustaining force behind the broader acceptance of recovery as the guiding principle for all that occurs in the formal system.

10.2.9 Summary

Professionally defined identities based on illness and disability can overwhelm individuality and become the way persons living with mental illness, and their families, are known — by

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462 10 May 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/15evc-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

463 See Chapter 3, Section 2, for a full discussion of "recovery."

caregivers, by society, by the media and by themselves. Social and systemic forces coalesce to present them a bleak future — unproductive, lonely and hopeless. Self-help supports the concept of recovery and responds to the full tapestry of people's individuality. Illness is only one part — perhaps even the smallest part — of a rich life fully worth living.

10.3 SELF-HELF AND PEER SUPPORT IN CANADA

Self-help constitutes people helping people — those who have "been there" sharing the common experiences of life-transforming events. A primary benefit of self-help is affiliation, "the great relief of knowing you are not alone."[464] In Canada, self-help and peer support have evolved in three ways.

A primary benefit of self-help is affiliation, "the great relief of knowing you are not alone".

10.3.1 Volunteer Organizations

Historically, self-help organizations have not received formal funding. The members have themselves defined the ways in which they support and sustain each another. Self-help or mutual aid (as it is also known) is based on the defining feature that all members are equal — all are experts on their own lives, no one knows more than anyone else and no one has all the answers.[465] Individual life experiences are the "knowledge base," and encouragement and hope the "methodologies" by which empowerment occurs and healing takes place.

Peers will likely have attended orientation or training programs to equip themselves with basic information on how to be most helpful; but they are volunteers, spending their own time with others whose journey, they hope, will be made easier by their presence.

> *Peer support is when a group of individuals who have experienced the mental health system come together regularly in a safe and comfortable environment to share each other's stories, be empathetic, and take the time to understand people. —Raymond Cheng*[466]

Peer support is also a form of self-help that includes one-to-one relationships between people who have had similar experiences. Like self-help, it is a system of "giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful."[467]

Peers see one another as individuals with stories to tell, rather than as "patients," "clients," or "cases" to be managed.[468] Peers may be further along in their own recovery than those

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464 Everett, B. (ed). (1994) You are not alone: A handbook for facilitators of self help and mutual aid support groups. Available through: Mood Disorders Association of Ontario.

465 Clay, S. (ed). (2005) On our own together: peer programs for people with mental illness. Nashville, TN: Vanderbilt University Press.

466 17 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/07ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

467 Mead, S., D. Hilton, and L. Curtis. (undated) Peer support: A theoretical perspective. Available at: www.mentalhealthpeers.com.

468 Canadian Mental Health Association, Ontario, the Centre for Addiction and Mental Health, the Ontario Federation of Community Mental Health and Addiction Programs and the Ontario Peer

they help — but mutuality of experience is always foremost. They spend time with the newly diagnosed, the freshly discharged and those in crisis. They offer information, resources and the reassurance that comes from sharing their own stories.

In preparation for their role, peers will likely have attended orientation or training programs to equip themselves with basic information on how to be most helpful; but they are volunteers, spending their own time with others whose journey, they hope, will be made easier by their presence.

> *We stress that we are not professionals but people who have lost a loved one through the act of suicide. Through our own stories, we help others share their grief and find a path to recovery. —George Tomie*[469]

10.3.2 Paid Peer Support

Some peer support workers are para-professionals employed by mainstream mental health or addiction service providers (hospital or community-based) working in Assertive Community Treatment (ACT) teams or outpatient counselling programs. Others may work in non-medical, community-based environments as staff hired for the life experiences that qualify them for the job, not for their professional expertise and qualifications.

Paid peer support workers can have many titles — Peer Advocate, Peer Counsellor, Peer Tutor, Case Manager Aid, System Navigator, Consumer Advisor, Peer Outreach Worker (www.mentalhealthconsumer.net) — the variety is bounded only by the limits of imagination. Unlike volunteers, they have been formally trained in the role. Many peer support programs include peers as members of mobile crisis teams and staff in safe houses and have been established out of the need to deal with psychiatric crises out-of-hospital.[470]

PROFILE

The Gerstein Centre is a 24-hour non-medical crisis centre located in downtown Toronto. It hires people based on life experiences to provide mobile crisis services, short-stay safe house residential care and telephone crisis counselling. Its philosophy: the environment and support offered are individualized, responsive to the needs and wishes expressed by the service user, and respectful of the autonomy, dignity and ability of the service user. It is the oldest program in Canada of its type and, this year, celebrates its 15th anniversary.

Development Initiative. (March 2005) Consumer/survivor initiatives: Impact, outcomes and effectiveness. Available at: www.ofcmhap.on.ca.

469 9 May 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/15evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

470 Mead, S., and D. Hilton. (2003) Crisis and connection. Psychiatric Rehabilitation Journal, Vol. 27, No. 1, 87-94.

10.3.3 Paid Peer Support Workers in Stand-Alone Consumer and Family Organizations

In 1991 the Ontario government established the Consumer/Survivor Development Initiative (CSDI) with an initial investment of $3.1 million (now $4.5 million). CSDI has since evolved into the Ontario Peer Development Initiative (OPDI). The philosophy that underpins the program is one of peer-to-peer support.

These funded organizations were not to provide such services as counselling or case management in the way professional organizations did, but to build upon the culture of mutuality and experiential knowledge that is at the centre of self-help. The resulting Consumer Survivor Initiatives (CSIs) employ peers in roles that include economic or community development, one-to-one peer support, social activities, peer education, advocacy and website communications.

PROFILE

The Ontario Peer Development Initiative (www.opdi.org) (OPDI) evolved from the Consumer/Survivor Development Initiative in response to the need, expressed by CSIs, for technical support. The organization offers assistance in board and organizational development, conflict resolution, along with membership and resource development.

10.3.4 Summary

The Committee recognizes the value of self-help and peer support organizations and is aware of the financial difficulties facing many such organizations across the country.

In Canada, as elsewhere, self-help and peer support programs have grown in an *ad hoc* fashion. Although some have been funded by governments, most exist independently of one another on shoe-string budgets and struggle for survival. But survive they do — on passion, commitment and dedication. Paid peer support has emerged in isolated pockets supported by provincial/territorial funding. As a new and tenuous addition to the mental health and addiction system, the future of self-help and peer support programs remains insecure.

> *We believe that the largest group of service providers are families, and that self-help groups are a significant support to persons with mental illness. Self-help groups have demonstrated their effectiveness in Manitoba. They are adjuncts to the mental health professionals for both patients-clients and families.*
>
> *Self-help groups must continue to be part of the system and spend their time assisting their members, as opposed to spending time and resources in fund-raising. Services should be devolved to them. Their individual approaches must be protected. —Annette Osted*[471]

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[471] 31 May 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/16eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

The Committee recognizes the value of self-help and peer support organizations and is aware of the financial difficulties facing many such organizations across the country. Therefore, the Committee recommends:

47	**That funding be made available through the Mental Health Transition Fund (see Chapter 16) that is specifically targeted at:** • **Increasing the number of paid peer support workers in community-based mental health service organizations.** • **Providing stable funding to strengthen existing peer development initiatives, build new initiatives (including family groups), and build a network of self-help and peer support initiatives throughout the country.** **That the federal government lead by example, building on innovations such as the National Peer Support Program for current and former Canadian Forces members and support, with appropriate levels of funding, self-help and peer support programs for the client groups that fall under the jurisdiction of the federal government.**

10.4 RESEARCH INTO SELF-HELP AND PEER SUPPORT

Testimony from persons living with mental illness, and their families, credits self-help and peer support for being effective and, in many cases, virtually life-saving.

> *I have no shame. I owe my life to the OSISS group (Operational Stress and Injury Social Support). —Corporal Clement*[472]

Testimony from persons living with mental illness, and their families, credits self-help and peer support for being effective and, in many cases, virtually life-saving.

Studies that evaluate the effectiveness of self-help and peer support are emerging. The research that is available has tended to be descriptive or has surveyed members' satisfaction.[473] But in the United States, an evolving body of research documents the outcomes of peer support programs,[474] and there are some recent Canadian studies noteworthy for their scientific rigour.

Nelson *et al.* examined four Consumer Support Initiatives in Ontario offering educational events, advocacy opportunities and social networking in addition to peer support.[475] When

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472 Maple Leaf. (February 2005) Canadian Forces Newsletter.

473 For example, Corring, D. (2002) Quality of life: Perspectives of people with mental illness and family members. Psychiatric Rehabilitation Journal, Vol. 25.

474 Campbell, J., and J. Leaver. (2003) Report from NTAC's National Experts meeting on emerging new practices in organized peer support. Available through: U.S. Department of Health and Human Services.

475 Nelson, G. (2004) What was learned about members of CSIs in Making a Difference. Available through: Centre for Addiction and Mental Health.

members joined these peer support groups, almost 40% were in unstable housing, one-third had been admitted to hospital in the past nine months and 25% reported the distress of psychiatric symptoms. After 18 months, they experienced fewer hospitalizations and fewer visits to emergency rooms than a control group of non-members. They had more stable housing, were experiencing fewer symptoms, and reported more friendships, all leading to an overall improvement in their quality of life. Qualitative data showed that members valued peer support as a safe place to recover and grow, protected from the negative judgments of society and the indifference of their communities.

Forchuk studied cost savings attributed to peer support.[476] Using a randomized cluster design, she examined the experiences of 390 patients in 26 hospital wards in southwestern Ontario. She found that peer support, in combination with inpatient follow-up until a discharged patient was connected to community services, saved $12 million in bed costs in one year. "Treating just one lonely person would pay for a part-time volunteer coordinator through reduced hospital and emergency costs."

A study of Consumer/Survivor Initiatives, also in Ontario, found that with peer support, members used fewer mental health services (hospital days dropped from 48.36 to 4.29, and crisis service contacts went from 3.54 to 0.81). Members also increased their social and community supports.[477]

In light of these findings the Committee recommends:

48	**That research be undertaken to:** • **quantify the benefits of self-help and peer support to participants,** • **identify savings to the health care system that result from peer support initiatives, and** **That a portion of these savings be redirected to support further self-help and peer support initiatives.**

Further to research on outcomes, there has been substantial effort in Canada to conceptualize how consumer and family knowledge can shape thinking related to clinical treatment, community service, and government policy. In an important reworking of the Framework for Support document for the Canadian Mental Health Association,[478] authors offer an idea called the Knowledge Resource Base which they argue is critical to the advancement of the understanding of mental health, mental illness and addiction. In

476 Forchuk, C. (2002) Therapeutic relationships: From hospital to community. Available at: Canadian Health Services Research Foundation, www.chrsf.ca.

477 Trainor, J., et al. (1997) Beyond the service paradigm: The impact of consumer/survivor initiatives. Psychiatric Rehabilitation Journal, Vol. 21, 132-140.

478 Trainor, J., E. Pomeroy, and B. Pape. (2004) A framework for support. Third edition. Toronto: Canadian Mental Health Association, National Office.

addition to traditional sources of knowledge that include evidence derived from social science (such as the outcome studies referred to above) and medical/clinical knowledge (studies of brain function, for example), the Knowledge Resource Base also includes experiential knowledge (the day-to-day lived understanding of illness as offered by persons living with mental illness, and their families) and the wisdom that comes from custom, tradition and history (honouring diversity and including other ways of healing).

> *I believe that peer support should be promoted and funded for people who have a personal experience with mental illness. Only individuals who have a mental illness truly understand what it is like to live with a mental illness. Because of that, we have a tremendous ability to help one another that the professionals just cannot match.*
>
> *Families also need peer support so they can support one another and help navigate the system and advocate for their loved ones.*
>
> *We would be more able to help one another if we had financial resources as so many people are also living in poverty or with very limited incomes. Transportation, communications by phone or internet is often not available to the individuals, themselves. —Anonymous*

10.4.1 Summary

Research focused on self-help and peer support is relatively new, but the findings are promising.

Research focused on self-help and peer support is relatively new, but the findings are promising. The theories that underpin the few studies that have been done and the methodologies employed are expanding the research horizon in new and innovative ways.

Importantly, people living with mental illness, and their families, are participating in the formulation of questions as well as in data collection and analysis and the dissemination of findings. Such knowledge transfer practices are taking mental health and addiction in evolving and promising directions.

Conceptual work, such as that evidenced by the new edition of Framework for Support, provides a rich discourse that is inclusive of consumer and family participation and establishes the value of their role in the creation of new knowledge.

Therefore, the Committee recommends:

49	**That the Canadian Institutes of Health Research (CIHR) support research into self-help and peer support, and that in determining which research projects to fund the CIHR utilize a review process that welcomes and understands the types of participatory methodologies that persons living with mental illness, and their families, prefer and find effective.**

10.5 NEW VOICES

Self-help and peer support, while a welcome addition to the array of treatment and community services, challenges traditional thought in a variety of ways. People living with mental illness have their own perspectives regarding the causes and treatment of mental illness and addiction. Families speak out about lack of access to services, their exclusion from the treatment of their loved ones, and the failure of governments to enact laws that permit involuntary treatment.[479]

10.5.1 Service Delivery

Forty-one percent of respondents participating in the Committee's e-consultation stated that their experience with service providers was negative.[480] Twenty-three percent described lack of respect as their worst experience, while others said misdiagnosis and inappropriate treatment (22%), delay in treatment (20%), physical violence (16%), denial of treatment (14%) and forced hospitalization (10%) constituted the worst. In the second phase of the e-consultation, persons living with mental illness, and their families, also distinguished between availability of services (hard to find) and their accessibility (the services are there, but there are too many barriers to getting access to them).[481]

Forty-one percent of respondents participating in the Committee's e-consultation stated that their experience with service providers was negative.

People living with mental illness, and their families, also reported to the Committee that they felt themselves to be objects to be "handled" rather than human beings sharing relationships with their health care professionals.

While acknowledging the contributions of professionals, persons living with mental illness say that they are often not listened to or treated as whole people. Their lives become a series of unconnected problems to be managed only in ways that fit the various professional specialties. People living with mental illness, and their families, also reported to the Committee that they felt themselves to be objects to be "handled" rather than human beings sharing relationships with their health care professionals.

The safety of self-help groups has allowed people to speak out and to publish their views. Their personal experiences add power to these narratives. As a result, professionals, policy makers, administrators and the public are being challenged to alter their traditional views about people with mental illness and addiction and the way services intended to meet their needs are structured and delivered.

> *Back home I can remember my own personal experience wanting to start a self-help centre and, I should note, wanting to do it in French. There was a lot of*

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479 See also Chapter 4, Section 4.3.3, for a related discussion of the power of Review Boards to order treatment.

480 Chodos, H., N. Pogue and T. Riordan. (2005) E-consultation on mental health, mental illness and addiction: Phase one. Parliamentary Information and Research Service, Library of Parliament.

481 Ascentum. (June 2005) Final report on the online consultation by the Standing Senate Committee on Social Affairs, Science and Technology.

opposition to that because they said, "There will not be any professionals around. Can you really do that by yourself?"

But we were deaf, we were stubborn, we never listened, and 18 years later I am here right now, and today that concept is accepted. Thus in that sense things have improved in that we have finally come to terms with the fact that mental health clients can do things by themselves, and for themselves, and they can have their own initiatives. —Eugene LeBlanc[482]

10.5.2 Recovery

Rather than using the language of diagnosis, symptoms, funding patterns, service utilization and economic burden, those living with mental illness speak of hope, recovery, connection, story-telling, healing journeys, loving attention, dignity, friends, spirituality, empowerment and the transformative power of crisis.[483] These are sophisticated ideas that are not easily measured and managed; they do not fit comfortably in a system that prefers standardized procedures, uniform measures of accountability and homogeneous evidence-based best practices.

Rather than using the language of diagnosis, symptoms, funding patterns, service utilization and economic burden, those living with mental illness speak of hope, recovery, connection, story-telling, healing journeys, loving attention, dignity, friends, spirituality, empowerment and the transformative power of crisis.

Families, while more supportive of psychiatry and medication than are those undergoing treatment, also advocate for services that lie outside the medical circle of care.

Families, while more supportive of psychiatry and medication than are those undergoing treatment, also advocate for services that lie outside the medical circle of care — for example, affordable housing, income support and work.

The focus is on wellness and not illness, on ability not disability, on becoming at ease with one's limitations and not remaining diseased within one's limitations, on focusing on the beginning of the recovery process and not on remaining stagnant within one's misery. —Joan Edwards-Karmazyn[484]

Despite their increasingly prominent role, people living with mental illness, and their families, do not feel generally that they are being heard; and there is evidence that this is so.[485] While it is true that recovery, as a defining construct, has appeared in mental health

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482 11 May 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/15eve-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

483 Mead, S. (2003) Defining peer support. Available at: www.mentahealthpeers.com.

484 14 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/22eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

485 Canadian Mental Health Association, Ontario, the Centre for Addiction and Mental Health, the Ontario Federation of Community Mental Health and Addiction Programs and the Ontario Peer Development Initiative. (March 2005) Consumer/survivor initiatives: Impact, outcomes and effectiveness. Available at: www.ofcmhap.on.ca.

literature (it has had a much longer history in the addiction field), its revolutionary potential is not well understood, nor has it been widely acted upon.

10.5.3 Summary

New voices and views are often not taken seriously because those who advance them may be expressing somewhat diverging points of view. They may not agree with one another and the language they use may not be typical of the mainstream. However, with respect to people and families affected by mental illness and addiction, these disparate voices offer the opportunity for a richer, more nuanced dialogue among all stakeholders. They also provide a route to improved measures of accountability.

The "customers" of the Canadian mental health and addiction system say that they cannot find services when they need them and that, when they are lucky enough to find help, they are often unhappy with the services they do receive.

This valuable information must serve to improve the targeting of future government investment and the oversight of outcomes.

The "customers" of the Canadian mental health and addiction system say that they cannot find services when they need them and that, when they are lucky enough to find help, they are often unhappy with the services they do receive. These criticisms are not vague or insubstantial. They point exactly to what is wrong. This valuable information must serve to improve the targeting of future government investment and the oversight of outcomes. Therefore, the Committee recommends:

50	**That accountability measures for mental health and addiction services include not just process issues such as numbers of visits, hours of counselling or dollars spent, but also address outcomes, such as respect, preservation of dignity, as well as a focus on hope and recovery, since these figure amongst the things that persons living with mental illness, and their families, value most.**

10.6 CONTRADICTIONS AND CHALLENGES

As self-help and peer support continue to grow and become more adept at competing for government and other funding, they are challenged to remain true to their roots while, at the same time, being buffeted with the complicated demands, strings and "administrivia" that accompany money.

10.6.1 Paid Work Versus Unpaid Volunteerism

Self-help and peer support are based on independence as a core value. This argues that one of the main reasons their members experience success and satisfaction is that such groups are free to provide help in their own creative ways without direction from the "outside," whether from funders or anybody else. Nevertheless, having work to do is important and

highly valued. Therefore, having the opportunity for a paid career as a peer support worker or on the staff of a funded self-help or peer support program is a very worthwhile goal to be pursued.

> *I want to be clear that [peer support] opportunities cannot be token ones. They deserve to be paid positions and paid at a wage that is a life-worth-living-wage; not a living wage, a life-worth-living-wage [emphasis added]. —Becky McFarlane*[486]

Having the opportunity for a paid career as a peer support worker or on the staff of a funded self-help or peer support program is a very worthwhile goal to be pursued.

Once self-help and peer support work is recognized as a paid profession, the door opens on all sorts of possibilities that offer the potential for considerable benefit: credentialling of peer support through formal education, emergence of sub-specialties, formation of associations, and regulation through codes of ethics and disciplinary boards. The danger to be avoided is that such traditional "structures" might transform self-help and peer support into something different, removing from them the fundamental reason for their effectiveness — the participation of their members solely on the basis of their lived experiences.

10.6.2 Funded (With Strings) Versus Unfunded (Poor But Free)

Once self-help and peer support work is recognized as a paid profession, the door opens on all sorts of possibilities that offer the potential for considerable benefit.

The accountability requirements that accompany funding by government and many granting bodies are onerous. Just completing applications is skilled, labour-intensive work. Mainstream organizations often employ staff specifically to satisfy their funders' demands for reports. The burden of data collection increases steadily, and mainstream programs are required to keep extensive electronic and paper records describing their service activities in relation to expenditures, all the while complying with security measures and privacy legislation. Self-help and peer support groups, by their very nature, do not ask for private health information; some do not even ask participants for their names or addresses. Their tradition is an oral one and their most valued activity, storytelling, defies conversion into data elements.

Lack of funding often contributes to the marginalization of self-help and peer support groups and ensures that, funded or unfunded, their voices are drowned out by the power of professional interests.

Many prominent self-help and peer support groups are effective without external funding (AA being the prime example). But there are also numerous examples of self-help organizations that compete successfully for grant money, receive government funds and raise funds through soliciting private donations.

But most live perpetually on a shoe-string budget without the means to mount the initiatives needed by their members or to maintain a presence at important decision-making tables.

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[486] 15 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/05evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

Many such groups have difficulty acquiring funding because they challenge the very system through which the money tends to flow. Some decide not to pursue government funding because of the pressures that may then be applied to change their ways of doing things. Whatever the reason, lack of funding often contributes to the marginalization of self-help and peer support groups and ensures that, funded or unfunded, their voices are drowned out by the power of professional interests.

> *All of those initiatives have one thing in common: They are undervalued, under-funded and, because they do not fall within the prevailing cultural framework of clinical and unionized services, they are not a priority for governments and are often seen as an afterthought. In many instances, tokenism is very much enshrined in the mental health system. —Eugene LeBlanc*[487]

10.6.3 The Limits of Best Practice Research

Concepts such as best practice have not served self-help and peer support well. The approach to models — of programs, of practice, of logic, of evaluation — that is common among professionals, does not translate well to the informality of the self-help culture. On the one hand, this has meant that not enough research has been done on the merits of self-help and peer support. On the other, because much traditional research has tended to discount the voices of people with direct experience of mental illness, it has cut itself off from the key source of information required to be able to assess outcomes of mental health interventions.

People living with mental illness, and their families, like many marginalized groups, have legitimate grounds for being suspicious of many traditional research methods, and for looking with greater favour on non-traditional methodologies such as participatory action research or underutilized ones such as qualitative methods. With the increased incidence of government funding, however, some groups are grappling with defining best practices, hoping that by adopting the methods of the professional culture they will gain respect and compete more effectively for funding.

> *The value of self-help and support groups in recovery has been very well documented. […]Financial support for promoting and funding this important area is much needed. The self-help movement is growing, but could do so at a much faster pace. —Susan Kilbridge-Roper*[488]

10.6.4 Summary

There is no doubt that tension exists between the informality of self-help and peer support and the formality of professional research methods and literature. In response to questions such as,

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487 11 May 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/15eve-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

488 9 May 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/15eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

- can and should peer-run support programs be classified, evaluated and understood by the same measures that govern services provided in the traditional mental health system, and

- would standardization of services supplant the healing bond of peer-to-peer relationships rendering them units of time at billable hours.[489]

it is very likely that peer support programs may not be able to reach their full potential if they do not embrace certification and accountability mechanisms. Therefore, the Committee recommends:

51	**That accountability requirements that are established for self-help and peer support groups do not impose an overly onerous burden on these groups, and that measures be taken to ensure that these groups are able to meet these requirements.** **That consumer and family-led certification and accreditation processes for self-help and peer support programs be developed and funded to ensure quality, and to sustain the unique contribution of self-help and peer support initiatives.**

10.7 SUSTAIN AND PROTECT

Self-help and peer support groups point out that the solutions they offer to people and families suffering from mental illness and addiction are more cost-effective than professional help.

While mainstream organizations assert that a lack of funds compromises their ability to be effective, marginalized groups often hear the opposite — that funding will spoil them. People living with mental illness, and their families, have fought their way onto the mental health and addiction stage, step by difficult step, making on the way valuable contributions to the ways in which we think and speak about mental illness and addiction. The ideal of recovery comes from their ranks, as does the transformative reorientation of mental health and addiction treatment, supports and services toward the goal of recovery.

> *How do you live day and night with a mental illness? Does it not make sense to talk to people who are living day and night with a mental illness? It makes perfect sense to me. —Linda Bayers*[490]

Indeed there are contradictions and disagreements among individuals and families affected by mental illness and addiction, but this is hardly unusual. It is also true that the skills and attributes necessary to recover from a mental illness or addiction — or, as a family member,

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489 Campbell, J., and J. Leaver. (2003) Report from NTAC's National Experts meeting on emerging new practices in organized peer support, pp. 31-32. Available from: U.S. Department of Health and Human Services.

490 10 May 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/15evc-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

to support yourself, a loved one, and to navigate the system — are not the same as those required to lead complicated non-profit organizations; but then again, health professional education does not encompass much in the way of administration or management expertise. Usually, at least in the health professions, such skills are learned on the job.

For decades, professional organizations have had substantial funding. They have built infrastructure (computers, software and trained financial and informatics staff) to meet their accountability requirements. Consumer and family self-help and peer support organizations must begin almost from scratch because of their history of no, or limited, funding.

Self-help and peer support groups (and the research that focuses on them) point out that the solutions they offer to people and families suffering from mental illness and addiction are more cost-effective than professional help. This assertion can hardly be disputed, given that they are providing help for free or at minimal cost. There is a danger that if such groups are excused from conforming to standard accountability procedures because of their lack of infrastructure, self-help and peer support will simply become more deeply entrenched as poor cousins, outside the circles of real power where the important decisions are made.

The Committee believes that the rewards of investing in self-help and peer support outweigh the risk that their cultures may be altered in unpredictable or negative ways. The key is to balance financial support with independence and the capacity to meet the necessary accountability requirements.

In case these fears seem trivial, it should be noted that the Australian mental health strategy, praised internationally for its focus on the involvement of consumers and their families and its values of hope and recovery, has encountered serious difficulties in sustaining its implementation. For example, funding for the National Resource Centre for Consumer Participation, despite excellent capacity-building work, was withdrawn in September 2004; it no longer exists.

The Committee believes that the rewards of investing in self-help and peer support outweigh the risk that their cultures may be altered in unpredictable or negative ways. The key is to balance financial support with independence and the capacity to meet the necessary accountability requirements.

The rise of the self-help movement in mental health and addiction heralds a significant change in the traditional power relations in our systems of care. With sufficient and regular funding, combined with ongoing government commitment and protection, its full benefits will be realized.

> *I believe that self-help initiatives such as consumer/survivor projects and many other self-help resources for mental health and addictions need to be formally recognized and acknowledged to be very effective and less threatening recovery solutions. As a result they require funding which is appropriate — and not shamefully lacking — for the excellent work that they do. —Anonymous*

Therefore, the Committee recommends:

52	**That existing and new consumer and family organizations be funded at an annualized, sustainable level.** **That broad-based coalitions be funded and built among self-help and peer support organizations so that they do not continue to exist in isolation but are able to form networks with one another.**

10.8 CONCLUSION

The informed perspective of persons living with mental illness, as well as that of their family, is invaluable. Their organizations must be supported through stable, adequate, annualized funding. They must also be included in public education, research and knowledge transfer activities and thereby support the growth and development of the structures and skills that enable all organizations providing services to people and families affected by mental illness and addiction to operate effectively.

PART IV

Research and Information Technology

CHAPTER 11:
RESEARCH, ETHICS AND PRIVACY

11.1 INTRODUCTION

> *Good information is a prerequisite to good decisions… This is particularly true in the case of mental disorders, which until recently have been largely overlooked as public health issues. — World Health Organization*[491]

Research is fundamental to developing the quality information needed for the effective planning and delivery of the whole spectrum of mental health services. Research is necessary to:

- increase the recognition and understanding of mental illness,
- demonstrate how prevention of mental illness can be best achieved,
- provide the foundation for strategies for early intervention in mental illness to reduce the severity of illness and lead to faster recovery,
- develop more effective treatments, and
- lead to better and more cost-effective interventions through the use of technology.

In recent years, considerable progress has been made in all of these areas. Research done in Canada over the years has contributed significantly, both nationally and internationally, not only to expanding knowledge about how the brain functions, but also to developing new drugs and to the better therapeutic management of mental disorders. This has helped to greatly expand the treatment options that are available to people living with mental illness.

Consequently, it is of utmost importance that Canada devote the resources needed for effective research, disseminate the results of research, translate those results into clinical practice, develop a national research agenda, and collect the data necessary to track mental health in Canada. People living with mental illness are particularly vulnerable and should be treated with special care when they are the subjects of research. This chapter will address each of these issues in turn.

[491] World Health Organization, Mental Health Global Action Programme, 2002, p. 14.

11.2 SOURCES OF FUNDING FOR MENTAL HEALTH RESEARCH IN CANADA

11.2.1 The Fundamental Role of the Canadian Institutes of Health Research

Population health research and health services research remain relatively weak in the areas of mental health, mental illness and addiction.

Most research in mental health and addictions in Canada is led by researchers in universities and teaching hospitals, although increasingly it is done in collaboration with colleagues from outside academe. The federal government, through the Canadian Institutes of Health Research (CIHR), is the major sponsor of this research. CIHR was created in 2000 from the previous Medical Research Council as part of the federal government's commitment to making Canada one of the top five research nations in the world.

CIHR has divided the full range of health research into 13 sectors, each represented by an Institute. These Institutes are strategic networks that span disciplinary and geographic boundaries. One of them, the Institute of Neurosciences, Mental Health and Addiction (INMHA), has become the focal point for research into mental health, mental illness and addiction in Canada. INMHA has a very broad mandate: supporting research on the brain, the mind, the spinal cord, the sensory and motor systems, as well as mental health, mental illness and all forms of addiction. INMHA also works with federal and provincial departments and agencies and with non-governmental organizations to develop and implement strategies for research and the training of researchers.

There is still much to be learned in Canada about best practices in providing care and support to individuals with mental illness and addiction, whether in inpatient care, outpatient care, crisis response, housing, employment or self-help.

As with CIHR-funded health research in general, research in mental health, mental illness and addiction encompasses the full spectrum of studies ranging from biomedical, to clinical, to health services, and to population health research. Most witnesses welcomed the inclusion of population health research and health services research in CIHR's mandate, areas of enquiry that had been excluded from the Medical Research Council's focus on biomedical research.

Population health research and health services research remain relatively weak in the areas of mental health, mental illness and addiction. Dr. Shitij Kapur and Dr. Franco Vaccarino, of the Centre for Addiction and Mental Health, told the Committee of the importance of redressing this situation given the effects of the broader determinants of health on mental illness and addiction.[492]

With respect to health services research, a literature review prepared for Health Canada in 1997 suggested that there is still much to be learned in Canada about best practices in providing care and support to individuals with mental illness and addiction, whether in inpatient care, outpatient care, crisis response, housing, employment or self-help. Even for

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[492] Kapur, S., and F. Vaccarino. (2004) Translating Discoveries into Care — Enhancing Research in Mental Illness and Addictions. Paper commissioned by the Committee, p. 5.

those interventions where there is the strongest evidence relating to their effectiveness, there remains a pressing need for more detailed information about what works for whom.[493]

A paper from the World Health Organization backs this finding up, suggesting that there are many gaps in mental health research.[494] According to the WHO,

- there have been few long-term follow-up effectiveness studies,
- research into the link between a population's mental health and public social and economic policies is lacking,
- the evidence base for some mental health strategies and programs is limited, and
- data on the relative costs and benefits of mental health interventions are sparse.

Dr. Rémi Quirion, INMHA's Scientific Director, told the Committee,

> *There is still a dearth of specific information in this country, regarding incidence, prevalence, treatments, treatment quality, and knowledge transfer.*[495]

More in-depth research is essential to generate the results necessary to guide decisions about who should receive treatment and where, what treatment interventions should be provided, and how to provide assurance that the care delivered is appropriate to the particular needs of those living with mental illness and/or addiction.

Significant gaps remain in our understanding of mental health and addiction, gaps that can be filled only by much more research.

The Committee recognizes the federal government's role in creating CIHR and its decision to create INMHA, as well as the contributions of Dr. Rémi Quirion, INMHA's Scientific Director. Significant progress has been made in the promotion and conduct of research into mental health, mental illness and addiction. Nonetheless, the Committee shares INMHA's concern that significant gaps remain in our understanding of mental health and addiction, gaps that can be filled only by much more research.

Currently, INMHA is engaged in a priority-setting exercise, seeking input from stakeholders in the development of its second five-year plan. The Committee is encouraged by this process. The Committee would like to note that it recommends in Chapter 10 of this report that CIHR develop a funding stream focused on research into self-help and peer support, a relatively new and promising area of treatment and recovery.

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493 Health Systems Research Unit, Clark Institute of Psychiatry. (1997) Best Practices in Mental Health Reform — Discussion Paper. Prepared for the Federal/Provincial/Territorial Advisory Network on Mental Health, Health Canada, pp. 27-28.

494 World Health Organization. (October 2004) WHO European Conference on Mental Health: Facing the Challenges and Building Solutions.

495 21 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/23eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

11.2.2 Federal Funding for Mental Health Research

CIHR is the largest public sponsor of research into mental health and addiction in Canada. In 2004-05, it allocated a total of $53.7 million to research in mental health and addiction from its total budget of approximately $700 million.[496] CIHR spent a further $98 million on research in the fundamental neurosciences, as well as all aspects of clinical, health services and population health research related to neurological diseases and disorders of the senses.

Approximately 60% of these funds were allocated through INMHA; the rest were allocated through other institutes such as the Institutes of Aboriginal People's Health, Gender and Health, Health Services and Policy Research, Population and Public Health, and Genetics. As with all of CIHR's resources, these funds were allocated in response to applications that were funded on the basis of scientific merit as assessed by CIHR's international peer review process. Approximately 30% of these funds were allocated as a result of CIHR's strategic initiatives.[497]

In addition to CIHR, two other sources of federal funding for research into mental health are the Social Sciences and Humanities Research Council (SSHRC) and the Natural Sciences and Engineering Research Council (NSERC). SSHRC supports research in the broad area of social psychology, and NSERC funds projects relating to fundamental psychological processes, their underlying neural mechanisms, their development within individuals and their evolutionary and ecological context. Neither SSHRC nor NSERC provide significant funds for mental health research. Together they contributed approximately $6 million to mental health research in 2002-2003.[498]

Other federal sources of funds for research into mental health and addiction may include Statistics Canada, Canada's Drug Strategy (which funds the Canadian Centre on Substance Abuse), Health Canada, Correctional Service Canada (Addictions Research Centre), and the Canadian Health Services Research Foundation. The Committee did not receive information on the levels of funding provided by these sources.

We will return below to the issue of whether or not the level of funding from the federal government is adequate after reviewing the availability of funding for mental health research from other sources.

11.2.3 Other Sources of Funding for Mental Health Research

Pharmaceutical discoveries are an important product of research into mental illness, because drugs are an essential component of the treatment options for people living with mental

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496 According to the CIHR's 2005-2006 Report on Plans and Priorities, its overall planned spending for 2005-2006 will be $811.7 million. However, CIHR officials told the Committee that this includes flow-through monies for the Canada Research Chairs and Networks of Centres of Excellence programs.

497 Quirion, R. (21 June 2005) Testimony before the Standing Senate Committee on Social Affairs, Science and Technology. See also: Canadian Institutes of Health Research. 2005-2006 Report on Plans and Priorities.

498 Standing Senate Committee on Social Affairs, Science and Technology. (November 2004) Report 1- Mental Health, Mental Illness and Addiction: Overview of Policies and Programs in Canada, Chapter 10, p. 221.

illness. In fact, the pharmaceutical industry is the largest single source of funding for health research in Canada. In 2004, it invested $1.6 billion in health research and development, approximately 27% of the total spent on health research in the country.[499] Just how much of that funding of research by the pharmaceutical industry in Canada goes into mental health and addiction is not known, but it is thought to be substantial. Because of the strong presence of private industry in this area, the federal government is not a major sponsor of research into pharmaceutical therapies for mental illness. However, recognizing the importance of providing assistance to researchers to turn discoveries into practice, CIHR does provide funding for commercialization activities.

In most provinces, governmental bodies provide funds to support mental health and addiction research (e.g., Fonds de la recherche en Santé du Québec, Ontario Mental Health Foundation, Manitoba Health Research Council, Centre for Addiction and Mental Health (Toronto), etc.). These organizations provide approximately $10 million per year, an important contribution to mental health and addiction research, but well short of the funding from the Canadian Institutes of Health Research.

In addition, many voluntary health organizations (VHOs), such as charities and foundations, can effectively respond to the support needs of different groups of people living with mental illness or addiction. Rarely, however, are such VHOs able to attract sufficient funds to sponsor research in the specific disorders on which they focus.

The pharmaceutical industry is the largest single source of funding for health research in Canada. Just how much of that funding of research by the pharmaceutical industry in Canada goes into mental health and addiction is not known, but it is thought to be substantial.

Moreover, there are only two national non-profit organizations whose mandates focus specifically on raising money to fund mental health and addiction research: the Canadian Psychiatric Research Foundation (approximately $1.1 million per year) and NeuroScience Canada ($160,000 to mental health and addiction research in 2004).[500]

Other VHOs collect funds almost exclusively for patient support and treatment. One of these, the Schizophrenia Society of Canada, has funded a total of 11 research fellows since 1994 using the proceeds of the $1.5-million capital endowment fund initiated by the late Dr. Michael Smith's donation of half of his 1993 Nobel Prize award.[501]

The stigma associated with mental illness and addiction creates significant barriers to its attracting appropriate publicity, getting corporate sponsorship, and raising funds for the support of research. This experience contrasts with that of other disease groups.

The Canadian Psychiatric Research Foundation (CPRF) told the Committee that the stigma associated with mental illness and addiction creates significant barriers to its attracting

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499 Statistics Canada. (July 2005) Estimates of Total Spending on Research and Development in the Health Field in Canada, 1988 to 2004. Science Statistics, Service Bulletin, Cat. No. 88-001-XIE, Vol. 29, No. 5.

500 This information was obtained from the organizations' Web sites: www.cprf.ca and www.neurosciencecanada.ca.

501 See the Schizophrenia Society of Canada Web site: www.schizophrenia.ca.

appropriate publicity, getting corporate sponsorship, and raising funds for the support of research. This experience contrasts with that of other disease groups such as cancer and cardiovascular disease, for which the respective health charities are strong and successful fundraisers and supporters of research:

> *CPRF faces a difficult challenge in raising awareness and research funds to determine the causes, treatments and ultimate cures for a variety of mental illnesses. Tragically, the stigma of mental illness persists and as a result, millions suffer unimaginable despair in silence, fearful of adverse personal consequences that public acknowledgement of their illnesses might bring. Under these conditions, awareness remains low, understanding minimal, support mechanisms few, misconceptions rife and critical funding for research is critically low.*[502]

Given the difficulty faced by VHOs in raising funds, the Committee recommends:

53	**That the Canadian Mental Health Commission (see Chapter 16) work with non-governmental health organizations to develop and strengthen their fundraising capacities in order to raise more funds for research on mental health and addiction.**

The federal government could increase the value of the funds available by forming strategic partnerships with the private and non-profit sectors. Patrick McGrath, who holds the Canada Research Chair in Pediatric Pain, told the Committee,

> *I think that the way to do it [get more money for mental health research] is to help CIHR partner, for example, with others to increase the pie. We do not have enough money in Canada in health research. We are still, even though it has improved dramatically, in the lower third of the G8 countries. It is not a matter of the CIHR having a lot of funding and they could just target that. Certainly targeted funding within CIHR is one good way, but I think it is more useful to collaborate with CIHR and try to grow the pie.*[503]

Voluntary organizations can also play an important advisory role in research into mental health, mental illness and addiction in Canada.

In fact, the main non-profit organization that funds research for mental health, the Canadian Psychiatric Research Foundation, told the Committee that it wants to have more partnerships with CIHR. The Committee believes that the same could be said of the private sector. While CIHR does engage in partnership activities, they could be increased. Therefore, the Committee recommends:

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502 Canadian Psychiatric Research Foundation. (June 2003) Brief submitted to the Standing Senate Committee on Social Affairs, Science and Technology, p. 2.

503 10 May 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/15evd-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

54	**That the Canadian Institutes of Health Research actively seek out more opportunities for research partnerships on mental health and addiction with the private and not-for-profit sector.**

In addition to funding research, voluntary organizations can also play an important advisory role in research into mental health, mental illness and addiction in Canada. Dr. Quirion told the Committee that when INMHA was created, it sought out and fostered collaboration with 60 volunteer and non-governmental organizations. These groups participated in drafting the Institute's strategic plan and in the development of a strategy for increased funding.[504]

People living with mental illness, their family members, and representatives from VHOs told the Committee of their desire to participate in the research process. They are well placed to combat the pervasive lack of understanding and stigma associated with mental illness but feel disconnected from the research enterprise. For example, where appropriate, they could assist in the creation of research questions and their representatives could sit on review panels. This would allow researchers to better identify priorities and conduct research that is most needed by the mental health and addiction sectors. Importantly, their participation would reinforce the human aspects of science and be a continual reminder of the need for the practical application of research outcomes.[505] The Committee therefore recommends:

55	**That the Canadian Institutes of Health Research formalize the involvement of non-governmental health organizations, persons living with mental illness and family members in the setting of mental health research priorities and participation in peer review panels.**

11.2.4 Targeted Funding Is Needed

> *(…) the funding of mental health and addictions research in Canada is currently inadequate. Mental health and addictions are under funded in an absolute and a relative sense. When one combines this systemic under funding, with the impact of stigma, the limitations of the NGOs fund-raising in this area as well as the lack of commercial incentives for a lot of these activities, the under funding becomes even more acute. Given that the other constraints cannot be easily overturned (stigma, limits to fund-raising in this area, lack of commercial incentives) — it is critical that the federal government show leadership in securing fair funding for mental health and addictions research.*
> *—Dr. Shitij Kapur and Dr. Franco Vaccarino*

504 6 May 2003, http://www.parl.gc.ca/37/2/parlbus/commbus/senate/Com-e/soci-e/14eva-e.htm?Language=E&Parl=37&Ses=2&comm_id=47.

505 Gray, J., President, Schizophrenia Society of Canada. (12 May 2004) Brief submitted to the Standing Senate Committee on Social Affairs, Science and Technology, p. 3.

The prevalence of mental illness and addiction in Canada is high and the economic burden enormous. A study on the global burden of disease estimates that mental illness accounts for 15.4% of the disease burden in established market economies, second only to cardiovascular disease (at 18%);[506] nearly as many individuals battle depression as have cardiovascular disease. The total direct and indirect burden to the Canadian economy of mental illness was estimated to be $14.4 billion in 1998.[507]

The proportion of health research dollars allocated to mental health, mental illness and addiction is woefully inadequate. An adequate level of resources must be allocated to make progress.

Many witnesses have argued reasonably that the huge burden of mental illness and addiction on society should be reflected directly in the funding dedicated to research into mental health, mental illness and addiction. Yet, several witness told the Committee that, applying this principle, the proportion of health research dollars allocated to mental health, mental illness and addiction is woefully inadequate. The Scientific Director of INMHA, Dr. Quirion, told the Committee,

> *We agree that mental health research funding is insufficient in Canada, given the socioeconomic cost associated with these illnesses. . . . If we consider what we call the burden of disease, cost to society and incidence of mental illnesses, Canada, via the Canadian Institutes of Health Research, CIHR, needs to invest more in mental health research.*[508]

The federal government, through CIHR, must accord research in mental illness and addiction higher priority than it currently enjoys.

The Committee is of the opinion that research in these fields is of enormous importance and that it can lead to meaningful improvements in the lives of people living with mental illness and addiction in Canada. However, an adequate level of resources must be allocated to make progress. The Committee is very concerned that adequate resources are not being devoted specifically to research relevant to mental illness and addiction, especially given their social and economic burden on Canadian society.

To summarize, CIHR is the dominant source of funds that are available across Canada for research into mental health, mental illness and addictions. Funds from the private sector are primarily devoted to pharmaceutical innovations, and the provincial agencies are not well funded. Moreover, due to the stigma associated with mental illness and addiction, the ability of non-governmental organizations to raise money to fund research in mental illness and addiction is much less than in other major areas of health, such as heart and stroke, cancer, diabetes and arthritis. Hence, the Committee is of the strong opinion that the federal

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506 Murray, C., and A. Lopez. (1996) The Global Burden of Disease: A comprehensive assessment of mortality and disability from diseases, injuries and risk factors in 1990 and projected to 2020. Harvard University Press.

507 Standing Senate Committee on Social Affairs, Science and Technology. (November 2004) Report 1- Mental Health, Mental Illness and Addiction: Overview of Policies and Programs in Canada, Chapter 5, p. 101.

508 21 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/23eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

government, through CIHR, must accord research in mental illness and addiction higher priority than it currently enjoys.

The Committee is very supportive of the work done by CIHR as a whole and by INMHA specifically. While the Committee could ask CIHR to reallocate resources internally, this would mean taking away resources from other important health areas and potentially starving nascent research communities of necessary funds. Instead, the Committee is of the opinion that additional, incremental funds should be provided to CIHR for the purposes of funding increased research into mental health, mental illness and addiction.

INMHA has a very broad mandate and serves a large research community. The Committee is concerned that simply increasing the funds available to INMHA could result in more funds going to support research in fields such as the neurosciences, rather than to research into the much less well funded areas, such as the psychological and social factors associated with mental illness and addiction, where attention is sorely needed. Hence, the Committee believes that additional funds should be allocated in a dedicated fund, similar to the HIV/AIDS research funding that the federal government already provides to CIHR.

Incremental funds should be provided to CIHR for the purposes of funding increased research into mental health, mental illness and addiction. Additional funds should be allocated in a dedicated fund, similar to the HIV/AIDS research funding that the federal government already provides to CIHR.

Also, as noted above, the clinical, population health research and health services research areas remain weak in the fields of mental health, mental illness and addiction. It is vital that efforts be made to close the significant gaps in our understanding in these areas, even if it must begin as far back in the research process as with the recruitment and training of first-class researchers. Another factor to keep in mind, as noted in the previous section of this report, is the importance of involving stakeholders in the decision-making process for research priorities. Therefore, the Committee recommends:

56	**That the Government of Canada commit $25 million per year for research into the clinical, health services and population health aspects of mental health, mental illness and addiction.** **That these funds be administered by the Canadian Institutes of Health Research (CIHR), through the Institute of Neurosciences, Mental Health and Addiction under the guidance of a multi-stakeholder board and in consultation with the Canadian Mental Health Commission (see Chapter 16).** **That this $25 million be incremental to the funding currently provided to the CIHR.**

The total CIHR budget will also affect the funds available for specific areas, including mental health and addiction. In its 2002 report on the state of the health care system in Canada, the

Committee called for an increase in the federal government's annual contribution to health research to 1% of the amount spent on health care.[509] Meeting this target this year could involve almost doubling CIHR's budget to $1.3 billion per year from the present level of $700 million.

While the Committee is encouraged by the significant increases in federal funding allocated to CIHR early in its life, this support has essentially plateaued at 0.5% of total health expenditures in the last few years. The Committee reiterates its strong support for attaining the 1% goal, and recommends:

57	**That the Government of Canada, within a reasonable time frame, increase its funding to health research to achieve the level of 1% of total health care spending.**

A number of submissions to the Committee also stressed the importance of capacity, and some witnesses emphasized that insufficient numbers of physicians are participating in mental health and addiction research and that a major deficiency remains the fact that too few clinician scientists are being trained to carry out crucial clinical trials. Dr. Quirion told the committee,

> *We hope to be able to convince the CIHR to set aside part of its budgetary envelope for training, and clinical research carried out by mental health and mental illness specialists.*[510]

This means not just getting young researchers interested in mental health but also making sure that qualified and experienced clinical practitioners also have opportunities to do research. The Committee shares these concerns and believes that additional funds should be devoted for the recruitment, education and training of more researchers and clinician scientists in order to expand Canada's capacity to do first-class research in mental health and addiction. One of the priorities in INMHA's strategic plan for 2001-2005 is the creation of more training opportunities for clinician scientists. INMHA has already carried out a number of activities in this area, such as its BrainStar program. However, the Committee believes that more can and should be done. Therefore, the Committee recommends:

58	**That the Canadian Institutes of Health Research, through the Institute of Neurosciences, Mental Health and Addiction, increase the funds available specifically for recruiting and training researchers and for clinical research on mental health, mental illness and addiction issues.**

[509] Standing Senate Committee on Social Affairs, Science and Technology. (October 2002) The Health of Canadians — The Federal Role, Vol. 6, Ch. 12.

[510] 21 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/23eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

11.3 DISSEMINATION OF RESEARCH FINDINGS

A major concern of researchers in mental health, mental illness and addiction is that there is currently no central database for all sources of funding. Neither is there an authoritative source of information on what is being investigated. The Canadian Psychiatric Research Foundation pointed out that there is no coordination among research funding bodies and no central responsibility for data collection. As a result, researchers find it difficult to negotiate their way through not only the government granting agencies, but also the private and the non-profit sector funding sources. The creation of a central database would not only help avoid duplication and overlap, it would facilitate communication among researchers. It would also help people living with mental illness, their families, and voluntary health organizations know what research was taking place.

Steps should be taken to: ensure that information about research funding opportunities is clearly communicated to researchers; facilitate interdisciplinary coordination and collaboration amongst the research community; and broadly distribute the findings of research to health care providers, people living with mental illness, and policy-makers.

Researchers may not be aware of research conducted in other areas of specialization which may affect their work, especially since mental illness and addiction issues cut across a wide diversity of disciplines. Provision of such information could encourage collaboration, enhance productivity and minimize the negative impact of competition among universities and hospitals. The Canadian Psychiatric Research Foundation recommended the establishment of a central database of research funding agencies that would encompass non-governmental sources of funding, a listing of what and where research is being conducted, and a site for maintaining a summary of research findings.[511]

The United Kingdom has undertaken an innovative approach to ensuring greater coordination amongst mental health researchers. In January 2003, the United Kingdom created the Mental Health Research Network, which is designed to provide infrastructure for mental health research.[512] It acts as a central point of information and reference, connecting service users and care providers to researchers and mental health professionals. It hosts large-scale research projects in mental health that require multiple centres, and conducts much of the governance and financial administrative work on behalf of researchers. The Network currently involves seven research hubs which represent differing geographical and cultural bases. The hubs bring together academics, clinicians, and those involved in health and social care.

The Network was created because small, localized studies were often not conducive to allowing researchers to draw valid, general conclusions. Also, poor integration of resources, experience and expertise limited the ability of some mental health researchers to attract support from major funding bodies. This led to research that failed to inform public policy, and lacked coherence, relevance and credibility with users and professionals.

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511 Canadian Psychiatric Research Foundation. (June 2003) Brief submitted to the Standing Senate Committee on Social Affairs, Science and Technology, p. 6.

512 See the Web site of the Mental Health Research Network: http://www.mhrn.info/.

Setting up a similar network in Canada would take considerable time and effort and would have to be adapted to fit Canadian circumstances. Nonetheless, it should remain a long-term goal.

In the meantime, it may be possible to adopt certain elements. In particular, steps should be taken to: ensure that information about research funding opportunities is clearly communicated to researchers; facilitate interdisciplinary coordination and collaboration amongst the research community; and broadly distribute the findings of research to health care providers, people living with mental illness, and policy-makers.

The Institute of Neurosciences, Mental Health and Addiction does currently endeavour to assist information and knowledge exchange amongst researchers, but not in a systematic fashion. The Committee believes that the work of dissemination would be best performed by an organization that is able to bridge the various levels of government, non-governmental organizations and research institutions. The Committee therefore recommends:

59	**That the Knowledge Exchange Centre to be created by the Canadian Mental Health Commission (see Chapter 16) incorporate, amongst other things, an Internet-based database of research funding agencies and funding opportunities, identify what research is being conducted and where, and include summaries of research findings from all levels of government, universities, and non-governmental organizations.** **That the Knowledge Exchange Centre also assist in the exchange of information by organizing conferences, workshops, and training sessions on mental health research.**

11.4 KNOWLEDGE TRANSLATION

Knowledge translation is about turning the knowledge gained through research into more effective services and products and, for example, a stronger, more effective mental health system. It involves more than dissemination of information among researchers; knowledge translation involves connecting basic research to clinical practice. Dr. Ashok Malla, Head of Research, Douglas Hospital (Montréal), told the Committee:

Knowledge translation is about turning the knowledge gained through research into more effective services and products and, for example, a stronger, more effective mental health system.

The dissemination and application of discoveries remain major challenges that will be overcome only by greater investment.

> *We need to define a clear pathway for transfer of knowledge with appropriate training. For example, we need to do studies in early intervention where we involve primary health care, teach them how to recognize mental illness early and then see if we can actually transfer that knowledge generally.*[513]

And Ms. Downey, Executive Director, National Aboriginal Health Organization, pointed to the need for knowledge translation to be culturally appropriate:

> *The relationship between knowledge translation and the need for culturally appropriate delivery of services and supports is recognized in many communities. We know that the mainstream approach to health care service delivery, while it addresses some of the needs, does not address all of them. Approaches that have been targeted towards Aboriginal communities over the last 25 to 30 years, we know are not working. We know that some of the health statistics are worse than they ever were. . . . Evidence-based community research on knowledge translation is necessary to determine the impact on quality of health services and products, and availability and use of cutting-edge research for community programming.*[514]

Without effective knowledge translation, ineffective or even harmful treatments may continue, while effective, evidence-based treatments may not be adopted by policy-makers and mental health service providers.

The translation of a new idea or discovery into an accepted practice has three distinct phases. The first is the basic discovery that identifies, for example, a new genetic association, a new method of delivering care, a new way of engaging patients in therapy or a new idea for using an established treatment. The second phase is proof-of-principle, the clinical trial phase, which involves translating that discovery into care and demonstrating that it works in a controlled setting. The third phase, dissemination and application, involves incorporating the new practice into the pre-existing continuum of care and the community.[515]

Eric Latimer, a health economist at the Douglas Hospital, told the Committee that mental illness and addiction research has had many successes at the discovery level, given the funding and number of researchers involved, but that the dissemination and application of discoveries remain major challenges that will be overcome only by greater investment.[516]

Knowledge translation is an important part of CIHR's mandate. One of its objectives, as laid out in its founding legislation, is to excel "in the creation of new knowledge and its translation into improved health for Canadians, more effective health services and products and a strengthened Canadian health care system, by promoting the dissemination of

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513 16 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/22evc-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

514 21 April 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/13evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

515 Kapur and Vaccarino (2004), p. 6.

516 6 May 2003, http://www.parl.gc.ca/37/2/parlbus/commbus/senate/Com-e/soci-e/14eva-e.htm?Language=E&Parl=37&Ses=2&comm_id=47.

knowledge and the application of health research to improve the health of Canadians."[517] Knowledge translation is also one of CIHR's three priorities, as outlined in its *2005-2006 Report on Plans and Priorities.*

One of the strategic priorities for INMHA is to promote linkage and exchange, through structured knowledge translation programs, between the research community and municipal, provincial and national levels of decision-makers as well as users of research results, including VHOs.

Witnesses agreed that this necessary, laudable goal could not be achieved at current levels of funding. During his testimony, Professor Tousignant, of the Centre de recherche et intervention sur le suicide et l'euthanasie, suggested that research budgets should contain funds dedicated to "scientific popularization."[518] Many others told the Committee that knowledge translation is not done well in mental health and addiction research.

The Committee believes that knowledge translation is vitally important to ensure that people living with mental illness or addiction have access to the most effective treatments identified by research. Therefore, the Committee recommends:

Knowledge translation is vitally important to ensure that people living with mental illness or addiction have access to the most effective treatments identified by research.

60	**That the Canadian Institutes of Health Research (CIHR), through the Institute of Neurosciences, Mental Health and Addiction, substantially increase its efforts in knowledge translation in relation to mental health, mental illness and addiction research.** **That CIHR work closely with the proposed Knowledge Exchange Centre in order to facilitate knowledge exchange among decision-makers, providers and consumer groups.**

11.5 A NATIONAL RESEARCH AGENDA

> *Mental health and mental illness are critical and we should have a national type of agenda… — Rémi Quirion*[519]

The Committee has found that in the area of mental health, mental illness and addiction there is no coherent policy or strategy in place to produce a coherent and coordinated response to the complex issues involved. Usually, mental disorders constitute

In the area of mental health, mental illness and addiction there is no coherent policy or strategy in place to produce a coherent and coordinated response to the complex issues involved.

[517] Canadian Institutes of Health Research Act, s. 4(h).

[518] 6 May 2003, http://www.parl.gc.ca/37/2/parlbus/commbus/senate/Com-e/soci-e/14eva-e.htm?Language=E&Parl=37&Ses=2&comm_id=47.

[519] 6 May 2003, http://www.parl.gc.ca/37/2/parlbus/commbus/senate/Com-e/soci-e/14eva-e.htm?Language=E&Parl=37&Ses=2&comm_id=47.

complex and chronic illnesses with a broad impact on society. Their determinants cut across many sectors, and their management involves many different health professionals.

Witnesses stressed the need for better coordination of efforts currently being undertaken by the federal and provincial governments, together with non-governmental organizations and the pharmaceutical industry, to deal with the many challenges posed by mental illness and addiction. In their paper for the Committee, Dr. Kapur and Dr. Vaccarino stated:

Witnesses agreed on the need for a national research agenda.

> *(...) the issues of mental illness and addictions defy simple solutions. These illnesses have multiple determinants — biological, psychological and social, and adequate responses to them require coordination of multiple sectors. At present, research in these areas is a well-intentioned but uncoordinated effort. We strongly call for the development of a national policy or guiding framework to form the bases for a coordinated effort in the areas of Mental Health and Addictions Research.*[520]

Greater coordination of research activities would benefit people living with mental illness or addiction. It is especially important that research is aligned with their needs.

Witnesses who addressed issues related to research in the mental health and addiction field agreed on the need for a national research agenda. In their view, such an agenda should build on current Canadian expertise, coordinate the currently fragmented research activities performed by a variety of bodies (governments, non-governmental organizations, pharmaceutical corporations) and ensure a balance among biomedical, clinical, health services and population health research applied to mental health, mental illness and addiction.

Importantly, many witnesses stressed that now is the time to address the critical issues in mental health and addiction research. In particular, Dr. Quirion stated:

> *The time is now. There is a great deal of expertise in Canada because of the national health care system. That allows us to collect data and to have data banks that are much more impressive than in the United States. Take the new genome research, for example. I think we could have a major impact and we should not be afraid to forge ahead. If we forge ahead with the expertise we currently have, we will succeed in finding the causes of brain diseases and of mental illnesses.*[521]

The Committee believes that greater coordination of research activities would benefit people living with mental illness or addiction. It is especially important that research is aligned with their needs. Given CIHR's leadership role in funding health research in Canada, the Committee recommends:

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520 Kapur and Vaccarino (2004), pp. 11-12.

521 6 May 2003, http://www.parl.gc.ca/37/2/parlbus/commbus/senate/Com-e/soci-e/14eva-e.htm?Language=E&Parl=37&Ses=2&comm_id=47.

61	**That the Canadian Institutes of Health Research, through the Institute of Neurosciences, Mental Health and Addiction, work closely with the Canadian Mental Health Commission (see Chapter 16), researchers, provincial and non-governmental research funding agencies, and organizations representing people living with mental illness or addictions in order to develop a national research agenda on mental health, illness and addiction.**

11.6 SURVEILLANCE

> *Surveillance is necessary to find out the extent of the problem. Discussions the Autism Society Canada has had with the Canadian Institute of Health Information, Statistics Canada and Health Canada have been frustrating. There is acknowledgement that Health Canada has the mandate to deal with surveillance but there is not the political will to actually carry it out. I strongly urge the committee to press Health Canada to act according to their mandate and carry out surveillance for all mental health and brain-based disorders. It is a concern that the only activity on this front at the moment is a pilot project that will use data collections that already exist, rather than building a system that will allow the collection of the data that is needed. . . . We need the federal Department of Health to take responsibility for surveillance issues, which will facilitate better decision making. —Lisa Simmermon, Public Relations Director, Saskatchewan Families for Effective Autism Treatment*[522]

Canada currently has no national picture of the status of mental health across the country. Collecting quality data will provide better information for policy and decision makers inside and outside of government, as well as service providers and consumer groups.

Canada currently has no national picture of the status of mental health across the country. That is, we lack a national information base on the prevalence of mental illness and addiction in all their diverse forms. We also lack the information system required to measure the mental health status of Canadians and to evaluate policies, programs and services in the fields of mental health, mental illness and addiction. This is a major roadblock to determining the level of mental health services and addiction treatments needed by the provinces/territories and the country as a whole, and to evaluate the quantity and quality of services currently provided.

Collecting quality data will provide better information for policy and decision makers inside and outside of government, as well as service providers and consumer groups. A surveillance system will provide measures that provinces could use to set targets on the way to reaching desired health goals and program outcomes.

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[522] 3 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/42454-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

Two witnesses told the Committee about the importance of a surveillance system. Dr. Wade Junek of the IWK Health Centre emphasized the need to have better measurement and information systems:

> *If the fundamental goal is to improve the mental health status, or maintain even what we have, for our children and youth, one, we have to measure that status to determine if the actions are having an effect. We have to have outcomes and measures. Two, we have to incorporate information about those measurements into our decisions to allow for corrective action.*[523]

Doug Crossman, Manager of Mental Health Services at the South Shore District Health Authority in Nova Scotia, told the Committee that it is important to have an outcome orientation.

> *We need better information systems and better population surveillance systems to monitor what we do and offer outcomes orientation. Frequently, we do not talk about outcomes. We talk about service utilization, which means the demand has grown on our service and so we need more money next year for more services. We should focus on what we are doing to improve the overall health of the population as opposed to expanding the service industry.*[524]

Ongoing data on mental health and addiction issues are being collected by federal agencies. For example:

- The Canadian Institute for Health Information (CIHI) collects information on hospitalizations in acute care hospitals and psychiatric facilities.
- Statistics Canada collects information on mortality, including statistics on suicide.
- The National Population Health Survey includes questions on alcohol addiction, stress, social support, a distress scale, and a depression scale.
- The National Longitudinal Survey of Children and Youth includes questions on mental health and mental illnesses for a cohort of children across Canada.[525]

Canada does not currently collect data on an ongoing basis on the prevalence of mental illness and addiction among Aboriginal peoples, homeless people and the prison population — groups that are at higher risk for mental disorders than the general population. Also, hospitalization and mortality data exclude the majority of people living out-of-hospital and being treated for their mental illness or addiction.

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523 10 May 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/15evd-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

524 9 May 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/15evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

525 Stewart, P. (2000) The Development of a Canadian Mental Illness and Mental Health Surveillance System: A Discussion Paper — Final Report. Prepared for the Canadian Alliance on Mental Illness and Mental Health.

While some of the data could serve as the foundation of a surveillance system, each of the relevant data sources has limitations. Another serious drawback is their narrow focus — they do not provide a comprehensive perspective on mental health and addiction in Canada.

In 2002, the Canadian Community Health Survey carried out by Statistics Canada provided, for the first time, prevalence rates for some mental illnesses, substance abuse disorders, suicidal ideation, and pathological gambling. However, Canada does not currently collect data on an ongoing basis on the prevalence of mental illness and addiction among Aboriginal peoples, homeless people and the prison population — groups that are at higher risk for mental disorders than the general population. Also, hospitalization and mortality data exclude the majority of people living out-of-hospital and being treated for their mental illness or addiction.

The Canadian Alliance on Mental Illness and Mental Health aims to have a proposal for a national mental illness surveillance system by March 2007.

The Canadian Alliance on Mental Illness and Mental Health has been advocating the establishment of a national surveillance system that could be used in planning, implementing and evaluating policies, services and programs. The Public Health Agency of Canada has recently identified mental health and mental illness as a priority area and has decided to enhance the surveillance of mental illness through the development of a national mental illness surveillance program. It will spend $400,000 over the next two years on a consultation process and on a select number of feasibility and demonstration projects. It aims to have a proposal for a national mental illness surveillance system by March 2007.[526]

The Committee supports the initial actions taken by the Public Health Agency. However, a lot of work will need to be done to provide a complete picture of the state of mental health in Canada. The Committee is deeply concerned that the anticipated scope and pace of the proposed project may not be sufficient. Therefore, the Committee recommends:

62	**That the Public Health Agency continue its efforts to develop in a timely way a comprehensive national mental illness surveillance system that incorporates appropriate privacy provisions.** **That the Public Health Agency expand the range of data collected in cooperation with other agencies, such as the Canadian Institute for Health Information and Statistics Canada, as well as other levels of government and organizations that collect relevant data.** **That, as it develops a comprehensive national mental health surveillance system, the Public Health Agency work with the Canadian Mental Health Commission (see Chapter 16).**

[526] Mao, Y., Director, Public Health Agency. (2005) Presentation at the workshop on Expanding Mental Illness Surveillance in Canada, March 23-24.

11.7 RESEARCH ON HUMAN SUBJECTS

The Committee strongly supports research into mental illness and addiction because it can lay the foundation for future advances in treatment and prevention. However, research involving people poses many risks: abuse, misuse, exploitation, breaches of privacy, confidentiality, etc. Research involving human participants must be designed and performed in accordance with the highest scientific and ethical standards, and must protect the dignity of individuals and their families who make this valuable contribution to scientific progress.

Research involving human participants must be designed and performed in accordance with the highest scientific and ethical standards, and must protect the dignity of individuals and their families who make this valuable contribution to scientific progress.

The Committee acknowledges that individuals living with mental illness and addiction are particularly vulnerable research subjects. While all subjects of clinical research are vulnerable to some degree, the vulnerability of individuals participating in clinical mental illness/addiction research warrants particular attention. It is of paramount importance to protect the rights and well-being of these research participants and to promote ethically responsible research.

Research advances should not be pursued at the expense of human rights and human dignity. But nor should protections be so stringent so as to potentially exclude this vulnerable population from vitally important research that can improve scientific knowledge about their conditions and even benefit them as individuals.

In order to ensure the ethical conduct of research involving human subjects, institutions receiving research funding from the three federal granting agencies — the Canadian Institutes of Health Research (CIHR), the Natural Sciences and Engineering Research Council (NSERC) and the Social Sciences and Humanities Research Council (SSHRC) —are required to adhere to the 1998 Tri-Council Policy Statement on Ethical Conduct for Research Involving Humans (TCPS). The TCPS specifies that research proposals should be reviewed by a Research Ethics Board which is charged with protecting the safety, privacy, and dignity of research subjects. Risks to the physical or mental well-being of participants are to be minimized; such risks must be balanced by benefits to the participants or society as a whole.[527]

An important part of the TCPS is that research involving humans may be undertaken only if the subjects give free and informed consent to their participation in the research.[528] Given that most individuals with mental illness function reasonably well, they will be able freely and competently to give or withhold their consent for participation in research. In some circumstances, however, the cognitive capacity of people living with mental illness can be impaired, adversely affecting their decision-making ability.

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527 Medical Research Council of Canada, Natural Sciences and Engineering Research Council and Social Sciences and Humanities Research Council. (1998) Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans, Article 1.

528 *Ibid.*, Article 2.

The TCPS emphasizes the importance of voluntary consent and has provisions for individuals who may not be legally competent to give consent. However, the mental capacity of people living with mental illness to make decisions can exist at different levels to varying degrees and can fluctuate over time. In law, there are no degrees of capacity or incapacity. In its brief to the Committee, the Canadian Catholic Bioethics Institute explained:

> *The legal system tends to distinguish sharply between those who are deemed "capable" of decision-making regarding their health care and those who are incapable. Many persons with an active mental illness, such as severe depression or schizophrenia, may not meet the legal criteria for being declared "incapable", and yet they do have significant impairment of their ability to understand their condition, appreciate their options, make prudent decisions about their mental health care and follow through on these decisions.*[529]

More study is required to develop better safeguards and special protections for the ethical treatment of people with mental illness and addiction as subjects in research.

The capacity to give consent is an essential condition for research involving human subjects. But the clinical assessment of mental capacity of people living with mental illness or addiction is a highly complex matter, and applicable clinical tests to assess competence are controversial. Illness may affect the ability to properly comprehend and assess the risks and benefits of participation in the research, or the steps required to implement the research plan. Also, given their vulnerability, people living with mental illness may feel coerced into participating.

The Committee understands that sometimes research into mental illness and addiction can be carried out only on people who have an illness that impairs their ability to give consent. However, the Committee is concerned that currently the guidance for research involving human subjects considers only the dichotomy of consent freely given or those who are not legally competent to give consent.

The unique circumstances and vulnerabilities attending mental illness and addiction merit close attention to the ethical design, review and conduct of research. One possibility is for people living with mental illness to have an advocate to assist them with the processes involved in research participation.

The Canadian Institutes of Health Research has undertaken studies into research ethics, including the secondary use of personal information in health research and the appropriate use of placebos in clinical trials.[530] However, the Committee feels that more study is required to develop better safeguards and special protections for the ethical treatment of people with mental illness and addiction as subjects in research. The Interagency Advisory Panel on Research Ethics, composed of experts from the three federal granting bodies is responsible for overseeing the development and evolution of the TCPS. Consequently, the Committee recommends:

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529 Canadian Catholic Bioethics Institute. (20 February 2004) Brief presented to the Standing Senate Committee on Social Affairs, Science and Technology, p. 5.

530 See the Canadian Institutes of Health Research Web site at: www.cihr-irsc.gc.ca.

63	**That the Interagency Advisory Panel on Research Ethics conduct a study involving broad consultations as to whether the Tri-Council Policy Statement on Ethical Conduct for Research Involving Humans provides adequate protections and sufficient guidance for research involving persons living with mental illness and addiction. The panel should also explore the possibility of using patient advocates for persons with mental illness participating in research.**

CHAPTER 12:
TELEMENTAL HEALTH IN CANADA

The concept of *telemental health* (telemedicine and telepsychiatry) was mentioned frequently during the Committee's hearings. The more general term telehealth refers to health care and other services offered through a variety of information and communication technologies (ICT). *Telemental health* refers to services for mental health care that are delivered at a distance through ICT.

Telemental health refers to services for mental health care that are delivered at a distance through information and communications technologies.

Telehealth is not limited to clinical care applications. It also encompasses the application of ICT to training and continuing education. Telehealth technology can be used for a variety of purposes including diagnosis, treatment, training, education and consultation.

The first includes electronic health records, databases and registries, all examples of "store-and-forward" applications involving data stored at one location being sent to another location for use. The second category is two-way interactive television (IATV), audio/visual communication between at least two sites.

The spectrum of applications can be classified into two main categories. The first includes electronic health records, databases and registries, all examples of "store-and-forward" applications involving data stored at one location being sent to another location for use. The second category is two-way interactive television (IATV), audio/visual communication between at least two sites. It is also known as communication in real-time, live feed or, more commonly, videoconferencing.

The Committee was advised that these technologies have considerable potential in the mental health field. Dr. Ted Callanan, President, Psychiatric Association of Newfoundland and Labrador, told the Committee that:

> *Psychiatry, perhaps, can offer the greatest range of its services efficiently and adequately via distance technology versus any other medical specialty.*[531]

12.1 CURRENT PROGRAMS

Nationally, Canada Health Infoway (CHI) was established as a strategic initiative of federal, provincial and territorial governments to provide leadership in the development of a capacity for nationwide health information management and to achieve better coordination of the wide and rapidly developing variety of health information and technology initiatives already under way across Canada. CHI's mission is to foster and accelerate the development and adoption of electronic health information systems with compatible standards and communications technologies on a pan-Canadian basis. It is building on existing initiatives and pursuing collaborative relationships with all the stakeholders involved with a view to achieving tangible benefits to all Canadians.

Infoway has 21 approved telehealth projects under way and has completed 14 others — a total of 35 projects with an estimated investment value of over $6 million.

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[531] 15 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/22evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

Electronic health records are CHI's highest priority at this time, with five of the six investment programs focused on this objective. The sixth program, telehealth, was added to CHI's mandate in 2003. Local, regional and provincial programs can now apply to CHI for funding of their telehealth initiatives. Information obtained by the Committee from CHI indicated that, at the time of writing, Infoway has 21 approved telehealth projects under way and has completed 14 others — a total of 35 projects with an estimated investment value of over $6 million. Infoway sees them as the foundation for more investments in the future.[532]

More resources are required for telehealth programs to reach their full potential.

The number of local and regional telehealth programs and pilot projects has increased considerably over the past decade. Nevertheless, a common theme voiced by witnesses was that more resources are required for telehealth programs to reach their full potential. Some observed that while such programs would be beneficial to the well-being of Canadians throughout the country, the approach taken to date has been too localized and telehealth initiatives generally have been under-funded, or have encountered too many regulatory or bureaucratic roadblocks to be truly helpful at the level of individual patients and providers.

Others, however, such as Dr. Martha Donnelly, Head, Division of Community Geriatrics, Vancouver General Hospital, indicated that some of these issues are being addressed:

> *There have been funding barriers that are now beginning to be overcome. There are potential medical and legal concerns...There are problems setting up the ports. Telehealth is not without cost...However, I think these things can be overcome.*[533]

Telemental health is one of the most frequently used of all telehealth services because the process of psychiatric diagnosis is not primarily a physical one but relies instead on verbal and non-verbal communication.

Indeed, an October 2004 Health Canada report entitled *Telemental Health in Canada: A Status Report* reinforces the testimony the Committee heard regarding the slow but sure progress being made to overcome some of these hurdles. According to the report, telemental health is one of the most frequently used of all telehealth services because the process of psychiatric diagnosis is not primarily a physical one but relies instead on verbal and non-verbal communication. In fact, the report indicates that "all provinces and territories have been experimenting with telemental health, and some have already embarked in program implementation."[534]

However, the status report also points to many of the same obstacles that witnesses brought to the Committee's attention, including the inadequacies of the current telecommunications infrastructure in this country and shortages and under-training in human resources. It notes that policies in areas such as health care delivery, reimbursement and licensure, designed for face-to-face care, will require modification if they are to be adapted to the requirements of long-distance care.

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[532] Alvarez, R., President and CEO, CHI. (7 November 2005) Letter to the Standing Senate Committee on Social Affairs, Science and Technology.

[533] 8 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/20ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

[534] Health Canada. (2004) Telemental Health in Canada: A Status Report, p. iii. Available on-line at www.hc-sc.gc.ca/hcs-sss/pubs/ehealth-esante/2004-tele-mental/index_e.html.

The Health Canada report lays out seven "lessons learned" that must be considered in order for Canada to advance its telemental health agenda effectively.

1. Careful planning is critical to the success of telehealth/telemental health services.
2. Uptake is always gradual and a project can take several years to fulfill its potential.
3. Evaluation should be built into every telemental health care program/initiative, and be adequately funded.
4. Despite limited evidence on cost-effectiveness, there seems to be real economies of scale.
5. Telemental health has demonstrated benefits to clients and providers, but the former are more easily converted than providers.
6. Telemental health presents a way to address shortages of mental health professionals but these same shortages can constrain its growth.
7. A comprehensive, multi-faceted strategy for managing change is crucial to success.[535]

The benefits and challenges of telemental health are discussed in more detail below.

12.2 BENEFITS OF TELEMENTAL HEALTH

12.2.1 Access to Care

Telemental health could allow people to be diagnosed and cared for in their communities.

The benefit from the wider deployment of telemental health (and all telehealth services) most frequently cited is its capacity to increase access to mental and other health services in rural and remote communities. Most mental health specialists are located in and around urban centres; residents of rural and remote communities must travel to those centres for diagnosis and treatment, a phenomenon referred to by some witnesses as "Greyhound Therapy." The considerable financial cost and expenditure of time and effort involved can discourage people from seeking the care they need. Telemental health, on the other hand, could allow people to be diagnosed and cared for in their communities. Rural health care providers would also gain access to psychiatrists and other providers of mental health services in urban centres and be able to consult with other specialists as well via ICT.

Telemental health offers the added benefit of helping to address issues that relate to the stigma associated with mental health care services.

By providing "low-profile" services to users, telemental health offers the added benefit of helping to address issues that relate to the stigma associated with mental health care services. Many people are discouraged from seeking the help that they need out of fear that it might become known that they are consulting a mental health specialist. Access to telemental health through a trusted family physician or other primary health care provider would therefore allow some rural residents to obtain mental health care services they might otherwise have declined to seek.

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[535] *Ibid.*, p. iv.

For example, in New Brunswick, the Region 2 Health Authority has connected telemental health terminals in small-town emergency rooms with the psychiatrists at the Saint. John Regional Hospital who are on call 24 hours a day. Not only has this improved access but it has also alleviated problems associated with stigma because patients no longer have to travel to receive care. Krisan Palmer, a registered nurse and coordinator of the region's telehealth initiatives, told the *Medical Post* that telemental health services have "really helped to establish patient confidentiality."[536] This regional initiative is now being rolled out province-wide.

12.2.2 Improving Recruitment and Retention in Rural Communities

Telehealth also has the potential to help ease the shortage of health care professionals in rural and remote areas. The current concentration of psychiatrists and other specialists in urban areas is unlikely to change in the near future. The use of ICT, however, could act as an incentive to attract and retain health care professionals in rural and remote regions of Canada. Telemental health can both help to provide necessary clinical back-up and foster connections between health professionals in remote areas and their urban peers.

Telehealth also has the potential to help ease the shortage of health care professionals in rural and remote areas.

Using technology such as videoconferencing, physicians and specialists can improve their education and enhance their knowledge by consulting with one another and by participating in conferences.

Rural areas remain unattractive to many physicians and specialists due to the professional isolation they face there. Many individual practitioners are averse to the reduced interaction with medical peers that is a fact of rural and remote practice settings, and the obligation to conduct their practice largely on their own. Telehealth can help to redress this situation by giving those practitioners access to other health care providers, including mental health professionals.

Another concern for many practitioners is that rural areas provide fewer opportunities for continuing medical education. Practitioners have to travel significant distances to attend conferences or to access other educational supports. Telemental health helps address this need. In this regard, Sharon Steinhauer, a member of the Alberta Mental Health Board, noted that "family doctors…can [have] not only immediate access to a psychitatrist and to psych. services support…but they can have ongoing training in those areas through telemental health sessions."[537] Using technology such as videoconferencing, physicians and specialists can improve their education and enhance their knowledge by consulting with one another and by participating in conferences.

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[536] Sylvain, M. (Nov. 15, 2005) Telemental health service reaches out to remote N.B. Medical Post, Vol. 41, Issue 49.

[537] 9 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/21eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

12.2.3 Collaborative Care

As noted earlier in this report, many regional health authorities are encouraging the creation of multidisciplinary teams in health care delivery. Collaborative care models of mental health care delivery are also becoming more widespread.[538] Telemental health facilitates the collaborative care model and cooperation between family physicians and psychiatrists.

Telehealth provides a means by which a collaborative model for mental health can be put into practice.

Although there are still barriers to be overcome (including the funding and remuneration issues described below), telehealth provides a means by which a collaborative model for mental health can be put into practice through video consultations, case conferences and educational sessions, Web-based training resources and continuing medical education programs.

Moreover, the Health Canada status report on telemental health points out that it is important to seek ways to integrate telemental health into the broader thrust of primary care reform, suggesting that:

> …telemental health be developed and implemented not in isolation, but as an integral part of the continuum of care. In this way, telemental health would have the potential to act as a catalyst for reform, particularly primary health care reform, according to key informants from many jurisdictions.

12.2.4 Aboriginal Communities

That telemental health services have the potential to improve access to care in rural and remote areas is of particular importance for many First Nations and Inuit communities. Access to psychiatric services in most northern Aboriginal communities is limited; the majority currently have none, and in others it is woefully deficient.[539] Often, communities share a single health care professional who travels between them or to whom clients must travel to obtain care. Mental health care professionals and other specialists are usually available only at great distances and the associated travel costs can be very high. Ian Potter, Assistant Deputy Minister, First Nations and Inuit Health Branch, Health Canada, told the Committee:

Once properly funded and implemented, telemental health could help to provide the level of service that is desperately needed in so many communities.

> *One promising area … is tele-mental health services, whereby we do not take people out of the community where they can actually communicate with others. Rather, we have them stay and talk to their relatives and provide them a link to psychiatric services in facilities elsewhere through a videoconferencing system.*[540]

Once properly funded and implemented, telemental health could help to provide the level of service that is desperately needed in so many communities.

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538 See Chapter 5 for a more detailed discussion of collaborative care.

539 See Chapter 14 for a more detailed discussion of the enormous challenges facing Aboriginal communities in improving the mental well-being of their people.

540 20 April 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/13eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

12.3 CHALLENGES

12.3.1 Jurisdictional Issues: Licensure and Reimbursement

Most provinces have yet to address adequately the issues related to reimbursement policies specific to their jurisdictions.

One of the most attractive features of telemental health — its capacity to offer services over vast distances — also presents one of the major challenges. The practice of medicine is a provincial/territorial responsibility; practitioners are licensed within each province or territory. A key benefit of telehealth activities is that it allows collaboration between mental health professionals across jurisdictional boundaries. However, regulating and funding this practice requires licensing agreements among the various jurisdictions in which health professionals participating in telemental health, or telehealth generally, are licensed and located.

While some jurisdictions have licensing agreements for cross-border practice, most do not. Licensing agreements between Prince Edward Island and Nova Scotia permit the sharing of some telepsychiatry services, but comparable agreements do not exist in most other parts of Canada. Their lack can make health care professionals hesitant to participate in telemental health initiatives.

Similarly, developing the right reimbursement policies represents another challenge that must be overcome if telehealth services are to be expanded. While licensing is the responsibility of the College of Physicians and Surgeons of each province or territory, the provincial and territorial governments must themselves address whether telemental health services are to be insured and paid for out of their publicly funded health plans.

Health Canada's status report asserts that most provinces have yet to address adequately the issues related to reimbursement policies specific to their jurisdictions:

> Most jurisdictions now have policies to reimburse physicians for telehealth (including telemental health), but these are generally considered inadequate for attracting service providers to telemental health. For example, as indicated by the key informants, in Alberta, physicians receive the same fee for a telehealth session as for face-to-face care, when in reality a telehealth session takes longer, according to key informants. Saskatchewan's physician payment schedule does include payments to compensate physicians for delays caused by technical problems. In Newfoundland, child psychiatry is the only telemental health service for which there is any fee-for-service reimbursement. In Manitoba, the fee schedule omits case conferences. In Quebec, the legislation specifically provides that telehealth is not an insured service. In British Columbia and Ontario, there are no fee-for-service provisions for patient/provider consultation through videoconferencing. In order to recruit service providers, project and program managers have attempted to mitigate the impact of inadequate fee-for-service policies by using contract agreements, salaried physicians and session fees paid out of project/program budgets.[541]

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[541] Health Canada. (2004) Telemental Health in Canada: A Status Report, p. 11.

The Committee therefore recommends:

64	**That the provinces and territories work together to put in place licensing agreements and reimbursement policies that will allow for the development of telemental health initiatives across the country.** **That the Canadian Mental Health Commission (see Chapter 16) work with the provinces and territories to identify and resolve any outstanding licensing and reimbursement issues.**

12.3.2 Funding

Telemental health activities began as temporary or pilot projects and have evolved into funded long-term programs. While some have secured the funding required to maintain their current level of operations, in many there is insufficient funding to expand or to create new projects. Up-front costs for a telemental health site include videoconferencing equipment, which can cost as much as $100,000 per system, while communication between sites requires additional funding for Internet, Integrated Services Delivery Network (ISDN) or satellite connection.

Although the federal government has provided financial assistance for the development of telemental health services, it does not implement or maintain these or other health services directly, with the notable exception of health services to those populations for which the federal government has responsibility (First Nations and Inuit, veterans, federal inmates, immigrants and refugees, military and the Royal Canadian Mounted Police). For this reason, telepsychiatry services are usually administered by provincial/territorial governments, academic institutions, regional health authorities or hospitals, or some combination thereof.

Funding and sustainability are a major issue for many programs, particularly in the North where telecommunication costs are very high due to a greater dependence on expensive satellite connections. The termination of a number of Health Canada initiatives has prevented the expansion of telemental health programs. Such now defunct initiatives related to telemental health include the Canada Health Infostructure Partnerships Program (CHIPP), Health Infostructure Support Program (HISP), Health Transition Fund (HTF), Knowledge Development and Exchange (KDE), and Applied Research Initiative. Many existing provincial/territorial programs that continue to operate were started under these programs.

It is important for the federal government to assist with the deployment of telemental health initiatives across the country.

As indicated above, Canada Health Infoway was created to help support, among other things, the development of telehealth programs. CHI funding, however, does not cover operating costs, networking infrastructure, or maintenance and enhancement of hardware, software systems and servers. Funding for such telemental health services comes largely from the provincial and territorial governments.

According to the previously mentioned Health Canada status report, all governments fund some telemental health services, but to significantly varying degrees. In some jurisdictions, uncertainty of

funding is a significant obstacle to expanding telemental health services. Ian Shortall, Division Manager, Bridges Program, Health Care Corporation of St. John's, told the Committee that "we need to use more technology, telepsychiatry… but have not been able to sustain the funding to carry that forward."[542]

The Committee believes that it is important for the federal government to assist with the deployment of telemental health initiatives across the country. In this respect, the Committee takes note of the announcement on 13 October 2005 that the Government of Canada has invested $4.62 million to advance broadband technologies that will support improved health care and emergency preparedness in rural regions.[543]

Extending the same funding ratio to the telehealth program as the others have would help to accelerate investments and advance telehealth.

Over time, and once the infrastructure is in place, it should be possible for the provinces and territories to use the savings from reduced transportation and other costs that will be gained by implementing telemental health services to fund the operating costs of those services. Meanwhile, in order to assist with the transition towards this "steady state," the Committee recommends:

65	**That telemental health initiatives be eligible for funding through the Mental Health Transition Fund (see Chapter 16).**

In addition, Richard Alvarez, President and CEO of Canada Health Infoway, informed the Committee of a restriction in its funding agreement with the federal government concerning telehealth: CHI can cover only up to 50% of eligible costs of telehealth projects.[544] This constraint does not apply to other CHI programs, in which the average funding ratio is now 75(Infoway):25(sponsor). The Committee agrees with Mr. Alvarez that extending the same funding ratio to the telehealth program as the others have would help to accelerate investments and advance telehealth in Canada. The Committee therefore recommends:

66	**That the funding agreement between Canada Health Infoway and the Government of Canada be revised so that Canada Health Infoway is no longer limited to being able to cover only up to 50% of eligible costs of telehealth projects and is allowed to establish the same ratio for its investments in telehealth projects as it uses in other projects.**

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542 14 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/22eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

543 Industry Canada (13 October 2005). Press release available on-line at http://www.ic.gc.ca/cmb/welcomeic.nsf/558d636590992942852564880052155b/85256a5d006b9720852570 9900672b4b!OpenDocument&Highlight=2,broadband.

544 Alvarez, R., President and CEO, CHI. (7 November 2005) Letter to the Standing Senate Committee on Social Affairs, Science and Technology.

12.3.3 Evaluation

Before any health service can be adopted as standard practice, it must first be thoroughly evaluated. A significant barrier to the implementation of new telemental health programs is the absence of standard evaluation practices. Since there are no national standards by which to evaluate telemental health projects, studies that assess the effectiveness of such projects do not use common sets of indicators and cannot be reliably compared to each other. Without consistent and reliable evidence relating to telemental health as an effective method of care, health authorities and provincial/territorial health departments are understandably reluctant to fund new projects.

The Committee therefore recommends:

67	**That the Knowledge Exchange Centre (see Chapter 16) work with the provinces and territories, as well as with other bodies such as the Canadian Institute for Health Information, in order to measure the cost-effectiveness of telemental health care delivery compared to traditional mental health service delivery.** **That the Knowledge Exchange Centre assist in the development of evaluation tools for telemental health services.**

12.3.4 Human Resources

The shortage of mental health professionals in many areas across Canada severely limits the development and implementation of telemental health services. As noted previously, telemental health can have a positive impact on attracting and retaining health care providers in rural and remote locations. However, getting telemental health services up and running can be difficult, especially when there is heavy competition for the use of scarce human resources. As stated in Health Canada's status report: "Telemental health represents a way around shortages of mental health professionals, but these same shortages can constrain its growth."

The provision of mental health services via telecommunications seems a very promising option, but it is still new. Many mental health care providers remain unfamiliar with telemental health, sceptical about its utility and, indeed, uncertain about their capacity to use it effectively. While some providers are now actively striving to adapt their skill sets in order to deliver care through telehealth, others are proving resistant to the conversion.

The Committee therefore recommends:

68	**That the Canadian Mental Health Commission (see Chapter 16) encourage the inclusion of telemental health instruction in medical schools, and that it work with the provinces and territories, as well as with the relevant professional bodies, to make information available on telemental health to current mental health providers through its Knowledge Exchange Centre.**

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PARTIE III

Organisation et prestation des services

CHAPITRE 9:
LA TOXICOMANIE

9.1 INTRODUCTION

L'un des plus grands problèmes, si je peux me permettre d'être très franc, c'est que les ministres doivent choisir entre les IMR et les toxicomanes. [Or, ceux-ci n'ont] pas de poids politique [...] — Michel Perron[377]

Au Canada, le traitement de la toxicomanie, tout comme celui de la maladie mentale, n'est pas érigé en système. Il a évolué de façon fragmentée et il a toujours été sous-financé, se déroulant dans la honte et se heurtant à l'indifférence du gouvernement. Pourtant, très peu de familles canadiennes n'ont pas été affectées par la toxicomanie[378]. Au cours de ses audiences, le Comité a entendu de nombreux témoignages sur les ravages causés par la toxicomanie : éclatement de la famille, pertes financières, prostitution enfantine, criminalité, itinérance, violence familiale et mauvais traitements infligés aux enfants, problèmes de santé concomitants, accidents de la route et du travail, perte d'emplois, anomalies congénitales, lésions cérébrales et suicides. La honte et le refus d'admettre la réalité empêchent souvent de reconnaître le lien entre la toxicomanie et ces conséquences. Lorsque des toxicomanes ont besoin d'aide et sont prêts à l'accepter, ils ont de la difficulté à trouver des services tout comme les membres de leur famille; quand ils ont accès à des services, ils sont souvent inscrits sur une longue liste d'attente. Pendant ces délais considérables, des personnes qui pourraient autrement recevoir de l'aide s'enfoncent davantage dans la toxicomanie ce qui entraîne des conséquences plus lourdes sur le plan humain et social.

Lorsque des toxicomanes ont besoin d'aide et sont prêts à l'accepter, ils ont de la difficulté à trouver des services tout comme les membres de leur famille; quand ils ont accès à des services, ils sont souvent inscrits sur une longue liste d'attente.

30 p. cent des personnes chez qui une maladie mentale a été diagnostiquée éprouveront aussi des problèmes de consommation d'alcool ou de drogues au cours de leur vie et que 37 p. cent des personnes alcooliques (53 p. cent des toxicomanes) souffrent également de maladie mentale.

Dans les cas où il y a à la fois des problèmes de santé mentale et des problèmes de toxicomanie, les clients ont le fardeau supplémentaire de faire la navette d'un service à l'autre.

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377 21 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/28ev-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

378 Dans le chapitre, le terme « toxicomanie » est utilisé pour simplifier la lecture. Il s'avère que la consommation et l'abus d'alcool et de drogues peuvent causer des méfaits sans qu'il n'y ait nécessairement toxicomanie : la consommation excessive d'alcool, l'état d'ébriété et la consommation non sécuritaire de drogues peuvent entraîner des problèmes de santé, des accidents de la route et des chutes et avoir d'autres conséquences néfastes. La consommation existe dans un spectre continu où l'on trouve à une extrémité la consommation sécuritaire et restreinte et à l'autre la toxicomanie; la possibilité de méfaits est toutefois présente d'une extrémité à l'autre.

Les services de santé mentale et les services d'aide aux toxicomanes fonctionnent dans des secteurs distincts. L'idée selon laquelle certaines personnes aux prises avec un problème de consommation pourraient aussi avoir des problèmes de santé mentale et vice versa a pris du temps à s'imposer. Les recherches ont toutefois révélé que 30 p. cent des personnes chez qui une maladie mentale a été diagnostiquée éprouveront aussi des problèmes de consommation d'alcool ou de drogues au cours de leur vie et que 37 p. cent des personnes alcooliques (53 p. cent des toxicomanes) souffrent également de maladie mentale[379].

Les clients et leur famille sont frustrés dans leurs efforts pour obtenir des services de santé mentale ou des services liés à la toxicomanie. Toutefois, dans les cas où il y a à la fois des problèmes de santé mentale et des problèmes de toxicomanie, les clients ont le fardeau supplémentaire de faire la navette d'un service à l'autre pendant que les professionnels débattent du problème devant faire l'objet du diagnostic principal.

> *J'ai obtenu de l'aide pour chaque chose, mais on se sent oublié du système quand on a besoin d'une aide combinée, pour tout à la fois [...] et, quand un de vos troubles est pire qu'un autre, le médecin pense que vous voyez quelqu'un d'autre, mais finalement personne ne vous traite. Il n'y a pas de suivi et on est tout simplement oublié. — Anonyme*[380]

Le Comité reconnaît qu'il n'a pu consacrer aux problèmes de consommation autant d'attention qu'il le prévoyait lorsqu'il a entrepris son étude sur la santé mentale, la maladie mentale et la toxicomanie. Il est conscient que le rapport porte principalement sur les problèmes de santé mentale et ne fait qu'effleurer les nombreux problèmes liés à la consommation de drogues qui méritent un traitement plus approfondi.

Bien sûr, de nombreux aspects de la maladie mentale et de la consommation se chevauchent, surtout quand il s'agit de personnes aux prises avec l'un et l'autre problème. Compte tenu de l'importance des problèmes de consommation en général et de ce chevauchement en particulier, le présent chapitre du rapport est consacré à ces questions. En outre, le chapitre 16 (Initiatives nationales pour la santé mentale) contient une importante recommandation visant l'injection par le gouvernement fédéral de 50 millions de dollars supplémentaires par année dans des programmes relatifs aux troubles concomitants.

9.2 LE VISAGE HUMAIN

Le milieu de la toxicomanie manque de porte-parole.

Un solide mouvement d'entraide et de sensibilisation créé par les clients et les familles vient appuyer les services de santé mentale. En ce qui a trait à la toxicomanie, l'entraide est très répandue depuis longtemps, mais elle fait partie d'une culture d'anonymat et d'autonomie recevant peu d'aide du gouvernement, ce qui

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379 W. Skinner, C. O'Grady, C. Bartha et C. Parker, *Les troubles concomitants de toxicomanie et de santé mentale : Guide d'information*, Centre de toxicomanie et de santé mentale, Toronto, 2004.

380 B. Rush, *Concurrent Mental and Substance Use Disorders: Why Is Such "Double Trouble" So Important?*, mémoire présenté au Comité sénatorial permanent des affaires sociales, des sciences et de la technologie, p. 7 [traduction].

pourrait expliquer pourquoi très peu de toxicomanes ou de membres de leur famille ont témoigné devant le Comité ou présenté des mémoires.

> *Clean and Sober Thinking (CAST) est un groupe d'entraide de toxicomanes non financé qui est établi dans la région de Peel (Ontario). Les rencontres des membres de CAST visent à aider les toxicomanes au moment crucial où ils sont prêts à changer. Lorsqu'une personne qui est dans l'enfer de la drogue ou de l'alcool décide de demander de l'aide, elle est enveloppée par la peur. Une intervention doit alors avoir lieu rapidement. Rien n'est aussi sécurisant que de recevoir l'appui de personnes qui sont passées par là — ou, dans le cas des rencontres de CAST, de personnes qui sont aussi à cette étape de leur vie. En Ontario, les initiatives de clients du secteur de la santé mentale sont bien établies et reçoivent du financement. Il n'existe rien de tel pour les toxicomanes*[381].

Les témoignages présentés au Comité n'ont donné qu'un petit aperçu de la douleur causée par les dépendances.

En ce qui a trait à la toxicomanie, l'entraide est très répandue depuis longtemps, mais elle fait partie d'une culture d'anonymat et d'autonomie recevant peu d'aide du gouvernement, ce qui pourrait expliquer pourquoi très peu de toxicomanes ou de membres de leur famille ont témoigné devant le Comité ou présenté des mémoires.

> *Je m'adresse à vous, à titre personnel, parce que ma propre fille, qui est atteinte de schizophrénie, prend du crack. [...] Comment attendre d'une personne atteinte d'une maladie mentale grave dont les facultés cognitives sont affectées, qui ne possède pour ainsi dire aucune motivation ou vision, et qui vit au jour le jour, de seulement envisager la désintoxication? Les interventions, de même que les ressources et les établissements de traitement sont désespérément insuffisants. L'attitude générale consiste à attendre jusqu'à ce que les personnes soient prêtes à cesser de consommer. Eh bien, elles ne veulent pas cesser de consommer. — Joan Nazif*[382]

> *Plus de gens que nous ne le croyons ont un problème de jeu compulsif — ils font des chèques sans provision, ils mentent, ils volent, ils s'absentent du travail dans le seul but d'éprouver immédiatement une sensation d'euphorie. Contrairement aux autres dépendances, le jeu compulsif peut être tenu secret. Il n'est pas accompagné d'une démarche vacillante, d'une difficulté d'élocution ou de traces d'injection. Pendant trois ans, aucun de*

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381 T. Reghr (septembre 2005), mémoire présenté au Comité sénatorial permanent des affaires sociales, des sciences et de la technologie, p. 2 [traduction].

382 6 juin 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/18eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

mes amis n'a su que je jouais. Je le faisais en solitaire, habituellement tard le soir. Les machines à sous, à tout prix, étaient ma grande obsession [traduction]. — Anonyme

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La dépendance aux médicaments antidouleur m'a dépouillé de ma dignité et m'a coûté très cher. À part voler l'argent des membres de la famille, j'ai trahi leur confiance et la foi qu'ils avaient en moi. À l'époque, rien n'était plus important que ce qui me permettait de « planer ». Je devais consommer de plus en plus de médicaments pour retrouver une sensation fugace. Les pilules exacerbaient les luttes quotidiennes que je devais mener. Je me suis finalement rendu compte de ce qui était devenu très clair pour beaucoup d'autres - ma vie était un gâchis. J'étais ruiné financièrement et mon moral était à son plus bas. — Barry Strader[383]

Le milieu de la toxicomanie manque de porte-parole; il n'y a donc que les décideurs et les fournisseurs de soins de santé pour défendre les intérêts d'une clientèle anonyme. Quels que soient les efforts qu'ils déploient à cet égard, rien ne peut remplacer le témoignage de personnes touchées par la toxicomanie. Des personnes aux prises avec la maladie mentale et des membres de leur famille ont présenté leurs points de vue aux gouvernements provinciaux et territoriaux en faisant valoir que l'aide provenant des organismes d'entraide est tellement importante qu'il faut financer ces organismes. Le fait que le secteur de la toxicomanie n'a pas exercé de pressions semblable crée une inégalité de représentation entre les deux secteurs qui ont tous *deux* un savoir-faire essentiel à offrir et un travail important à accomplir.

Le Comité recommande donc :

40	**Qu'une partie de l'aide financière accordée par le Fonds de transition en santé mentale (voir le Chapitre 16) au soutien par les pairs serve à l'établissement et au maintien de groupes d'entraide pour les personnes aux prises avec une dépendance (y compris les joueurs compulsifs) et leur famille.**

[383] B. Strader, mémoire présenté au Comité sénatorial permanent des affaires sociales, des sciences et de la technologie.

9.3 DES COUPABLES BIEN CONNUS ET LE TORT QU'ILS CAUSENT

Bien que la production et le trafic de drogues illicites fassent les manchettes, ce sont des produits qu'on peut se procurer légalement, soit l'alcool[384] et les médicaments sur ordonnance, qui sont les plus lourds de conséquences pour la vie et la santé des Canadiens, notamment en raison de leur prépondérance et de leur usage répandu[385].

> *Lorsqu'on pense à une personne qui a une dépendance, on ne pense généralement pas à la dépendance à l'alcool. Et lorsqu'on pense aux alcooliques, on se représente un pauvre hère assis dans une ruelle avec, à côté de lui, un flacon dans un sac de papier. On ne pense pas à la personne qui boit à domicile, ni aux personnes qui surconsomment des médicaments prescrits ou d'autres produits. Le jaunisme des médias ne nous aide pas, parce que les journaux ne font état que des histoires à sensation et ne parlent pas de la vie quotidienne des gens. — Sénateur Cordy*[386]

Ce sont des produits qu'on peut se procurer légalement, soit l'alcool et les médicaments sur ordonnance, qui sont les plus lourds de conséquences pour la vie et la santé des Canadiens, notamment en raison de leur prépondérance et de leur usage répandu.

L'ampleur du problème de la consommation abusive de substances licites au Canada est souvent passée sous silence en raison du caractère honteux qui s'y rattache et du refus d'admettre la réalité. Néanmoins, les faits sont clairs :

L'exposition prénatale à l'alcool est aujourd'hui considérée comme la *principale* cause des anomalies congénitales en Amérique du Nord.

Les Canadiens sont parmi les plus grands consommateurs au monde de médicaments utilisés en psychiatrie. Ils se classent au deuxième rang des consommateurs de sédatifs et au quatrième rang des consommateurs de médicaments sur ordonnance.

- 13,6 p. cent de tous les Canadiens sont considérés comme des buveurs à risque élevé[387].
- On estime qu'au cours d'une année donnée, 8 p. cent des hospitalisations et 10 p. cent du nombre total de jours passés à l'hôpital sont attribuables à la consommation abusive d'alcool et de drogues[388].

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384 Le tabac a lui aussi d'importantes conséquences négatives sur la santé.

385 Tim Stockwell, Michel Perron, Greg Purvis et Jeff Wilbee, 21 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/28ev-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

386 21 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/28ev-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

387 Centre canadien de lutte contre l'alcoolisme et les toxicomanies (mars 2005), *Enquête sur les toxicomanies au Canada (ETC) — Une enquête nationale sur la consommation d'alcool et d'autres drogues par les Canadiens — La prévalence de l'usage et les méfaits.* Voir : www.ccsa.ca.

388 E. Single, L. Robson, X. Xiaodi et J. Rehm (1996), *Les coûts de l'abus de substances au Canada.* Voir : www.ccsa.ca.

- L'exposition prénatale à l'alcool est aujourd'hui considérée comme la *principale* cause des anomalies congénitales en Amérique du Nord[389].

- En 2000, 981 personnes ont péri dans des accidents de voiture liés à l'alcool au Canada (y compris des piétons et des personnes utilisant des véhicules hors route)[390].

- Les Canadiens sont parmi les plus grands consommateurs au monde de médicaments utilisés en psychiatrie. Ils se classent au deuxième rang des consommateurs de sédatifs et au quatrième rang des consommateurs de médicaments sur ordonnance[391].

- On estime que 20 p. cent des Canadiens de plus de 60 ans sont des consommateurs de longue date d'analgésiques.

Au Canada, la consommation abusive de substances licites (y compris le tabac) entraîne annuellement des pertes de productivités de 11,8 milliards de dollars.

- Les femmes sont 50 p. cent plus susceptibles que les hommes de consommer des médicaments de façon abusive. Les Autochtones courent un risque plus élevé de consommer à des fins non médicales des médicaments sur ordonnance[392].

La grande majorité des Canadiens toxicomanes consomment des substances licites.

- Au Canada, la consommation abusive de substances licites (y compris le tabac) entraîne annuellement des pertes de productivités de 11,8 milliards de dollars, soit 1,7 p. cent du produit national brut (PNB), ce qui représente 414 $ par habitant (hommes, femmes et enfants confondus)[393].

> *En gros, je dirais que 90 p. cent des décès causés par les drogues sont attribuables à l'alcool et au tabac. Et si on tenait compte de l'invalidité et de la perte de qualité de vie, ces deux substances seraient probablement responsables de 95 p. cent des cas. Cela ressort très clairement de l'analyse effectuée par l'Organisation mondiale de la santé, y compris dans les pays économiquement développés. — Tim Stockwell*[394]

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389 Santé Canada. Santé des Premières nations et des Inuits (2004), *Stratégies relatives à l'évaluation des programmes de lutte contre l'abus des substances chez les Autochtones : Examen de la question.* Voir : www.ccsa.ca.

390 Conseil canadien de la sécurité (2005), *Les statistiques sur les accidents liés à l'alcool.* Voir : http://www.safety-council.org/CCS/sujet/route/alcool/stats.html.

391 J. Rehm, et J. Weeks (2005), « Dépendance aux médicaments d'ordonnance », *Toxicomanie au Canada : Enjeux et options actuels,* Ottawa, Centre canadien de lutte contre l'alcoolisme et les toxicomanies. Voir : http://www.ccsa.ca/CCSA/FR/Research/Policy_Activities/SubstanceAbuseinCanada.htm.

392 *Ibid.*

393 Centre canadien de lutte contre l'alcoolisme et les toxicomanies et Centre de toxicomanie et de santé mentale (1999), *Profil canadien : L'alcool, le tabac et les autres drogues.* Voir : www.ccsa.ca.

394 21 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/28ev-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

En fait, la grande majorité des Canadiens toxicomanes consomment des substances licites. Beaucoup d'entre eux ont une dépendance croisée, ce qui signifie qu'ils consomment diverses combinaisons d'alcool et de médicaments. La toxicomanie est un problème de santé dont l'incidence peut être réduite grâce à un suivi des interventions (relatives à la consommation de médicaments sur ordonnance, par exemple) et à la sensibilisation du public aux dangers à cet égard.

Le Comité recommande donc :

41	**Que les ressources en matière de traitement de la toxicomanie visent également la dépendance aux substances licites telles que l'alcool, le tabac et les médicaments sur ordonnance, et les comportements comme le jeu compulsif.**

9.4 UNE NOUVELLE MENACE — LE JEU COMPULSIF

Les spécialistes craignent que la plupart des problèmes liés au jeu demeurent cachés en raison de la honte et de la réprobation sociale qui s'y rattachent.

Les jeunes de niveau secondaire jouent de deux à quatre fois plus souvent que la population en général.

Le nombre de joueurs compulsifs a connu une hausse importante au cours des 25 dernières années. En Ontario, on estime que 3,8 p. cent des citoyens (340 000 personnes) éprouvent des problèmes allant de modérés à graves liés au jeu; 0,9 p. cent de la population a une forte dépendance au jeu[395]. En 1999-2000, les profits nets générés par le jeu (après l'attribution des prix et les autres dépenses) pour tous les ordres de gouvernement étaient de 5,7 milliards de dollars[396]. En 2004, ces profits étaient passés à 6,2 milliards de dollars, montant supérieur aux revenus nets que le gouvernement tire à la fois du tabac et de l'alcool (5,9 milliards de dollars)[397].

La Colombie-Britannique, le Manitoba, le Québec, l'Alberta, l'Ontario et l'Île-du-Prince-Édouard mettent en œuvre des programmes de « jeu raisonnable » pour lutter contre le jeu compulsif. L'engagement de l'Ontario à cet égard est de 2 p. cent des revenus bruts provenant des machines à sous dans les casinos de charité et les hippodromes; il s'agit de l'affectation la plus importante de fonds à une stratégie de lutte contre le jeu compulsif dans le monde. Toutefois, un récent examen a révélé que les fonds n'avaient pas été entièrement attribués (seulement 21,7 des 36 millions de dollars affectés ont été attribués en

395 R. Simpson, mémoire présenté au Comité sénatorial permanent des affaires sociales, des sciences et de la technologie.

396 Canada West Foundation (2001), *Gambling in Canada 2001: An Overview*. Voir : www.cwf.ca.

397 W. Skinner (septembre 2005), mémoire présenté au Comité sénatorial permanent des affaires sociales, des sciences et de la technologie.

2003-2004). Un nombre de joueurs compulsifs moins important (5 900) que prévu (8 600) ont demandé à suivre un traitement[398].

Les spécialistes craignent que la plupart des problèmes liés au jeu demeurent cachés en raison de la honte et de la réprobation sociale qui s'y rattachent, mais qu'ils apparaîtront plus tard et en nombre effarant. Le fait que les jeunes de niveau secondaire jouent de deux à quatre fois plus souvent que la population en général en est un signe précurseur. Ils sont les joueurs compulsifs de demain[399].

Au Canada, tous les ordres de gouvernement dépendent des revenus tirés du jeu; il y aura vraisemblablement une hausse de l'investissement dans les installations de jeu. Les incidences sociales, économiques et de santé sur les Canadiens commencent tout juste à poindre et ne doivent pas être négligées ni minimisées.

Le Comité recommande donc :

42	**Que les gouvernements provinciaux et territoriaux affectent une partie fixe des revenus tirés du jeu à des programmes de prévention, de sensibilisation et de traitement fondés sur des données probantes et à la recherche sur le jeu compulsif.** **Que Statistique Canada s'assure qu'à l'instar de la consommation d'alcool et de drogues, le jeu compulsif au sein de la population est mesuré et fait l'objet de rapports à la suite de sondages réguliers.**

9.5 LES PERSONNES LES PLUS VULNÉRABLES

Les gens qui sont pauvres, marginalisés ou autrement défavorisés sont touchés en nombre disproportionné par la toxicomanie ou le jeu compulsif. Les enfants et les jeunes, les femmes et les personnes âgées sont particulièrement vulnérables.

Comme c'est le cas pour d'autres problèmes de santé, les gens qui sont pauvres, marginalisés ou autrement défavorisés sont touchés en nombre disproportionné par la toxicomanie ou le jeu compulsif. Les enfants et les jeunes, les femmes et les personnes âgées sont particulièrement vulnérables, ce qui n'est pas toujours reconnu et n'est donc pas examiné.

9.5.1 Premières nations, Inuits et Métis

Comme il est expliqué au chapitre 14, les Autochtones attribuent leurs problèmes de santé mentale et de toxicomanie à la colonisation qui a brimé leur culture et créé un climat

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398 S. Sadinsky (mars 2005), *Review of Problem Gambling and Responsible Gaming Strategies of The Government of Ontario: A Report to the Ontario Ministry of Health and Long-term Care and the Ministry of Economic and Trade Development.* Voir : www.health.gov.on.ca/.

399 Youth Gambling International (2004), *Youth Problem Gambling.* Voir : www.education.mcgill.ca.

d'intense désespoir[400]. Le déplacement constant des collectivités et le retrait des enfants de leur milieu pour les placer dans des pensionnats ont ébranlé les liens traditionnels avec la famille et la collectivité; des générations entières ont été déplacées et traumatisées. Il en est résulté une faible identité culturelle, la pauvreté, la dépendance à l'aide sociale et un profond sentiment de détresse[401].

Les membres des Premières nations, les Inuits et les Métis souffrent d'une multitude de problèmes de santé, dont la toxicomanie n'est pas le moindre.

> *Dans le seul Labrador, comme l'a dit le témoin de la réserve, il y a eu énormément de suicides chez les jeunes. Ce n'est pas un phénomène qui frappe seulement le Labrador : cela se produit aussi à St. John's et dans toute la province, à cause de la dépression. Il y a aussi dans cette province énormément de suicides liés à l'utilisation des appareils de loterie vidéo et [...] à des surdoses de stupéfiants[.] — Harold Dunne*[402]

9.5.2 Les femmes

La situation des femmes diffère de celle des hommes à bien des égards, notamment sur le plan des réactions à la consommation d'alcool ou de drogues. Par exemple, les femmes courent plus de risques que les hommes de développer une cirrhose du foie en consommant moins d'alcool et en moins de temps que ceux-ci[403]. Elles sont aussi plus susceptibles d'être victimes de violence familiale, de mauvais traitement pendant l'enfance et de violence sexuelle; les femmes qui ont vécu de telles expériences courent un risque plus grand d'avoir des problèmes de consommation[404]. La question des femmes en âge de procréer qui consomment de l'alcool ou des drogues est particulièrement préoccupante compte tenu des risques de mettre au monde un enfant ayant des anomalies congénitales.

La question des femmes en âge de procréer qui consomment de l'alcool ou des drogues est particulièrement préoccupante compte tenu des risques de mettre au monde un enfant ayant des anomalies congénitales.

> *Le système profiterait d'un plus grand nombre de services aux femmes marginalisées (séances d'information données à des endroits où se rassemblent naturellement les femmes à risques élevés). Ces services permettraient d'identifier les femmes enceintes et celles qui ont des enfants et de les encourager à entreprendre un traitement. D'autres groupes tels*

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400 C. Brant (1993), « Le suicide chez les peuples autochtones canadiens : causes et prévention », *Sur le chemin de la guérison,* Rapport de la Table ronde nationale sur la santé et les questions sociales, Ottawa, Commission royale sur les peuples autochtones.

401 B. Mussell, K. Cardiff et J. White (2004), *The Mental Health and Well Being of Aboriginal Children and Youth: Guidance for New Approaches and Services.* Voir : www.mheccu.ubc.ca.

402 14 juin 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/22eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

403 American Liver Foundation, *Cirrhosis: Many Causes.* Voir : http://www.liverfoundation.org/db/articles/1059.

404 N. Bradley (septembre 2005), mémoire présenté au Comité sénatorial permanent des affaires sociales, des sciences et de la technologie [traduction].

que les femmes âgées, les jeunes femmes, les toxicomanes qui sont souvent sans-abri et les délinquantes. Très souvent, ces femmes n'ont pas accès aux services; nous devons aller vers elles en faisant preuve de compréhension et de sensibilité. — Nancy Bradley[405]

9.5.3 Les aînés

Jusqu'à 18 p. cent des personnes âgées hospitalisées le sont pour des raisons liées à une consommation abusive d'alcool. Les aînés prennent davantage de médicaments sur ordonnance et, de ce fait, ils sont particulièrement vulnérables aux effets indésirables et aux interactions des médicaments et à la dépendance aux médicaments.

Jusqu'à 18 p. cent des personnes âgées hospitalisées le sont pour des raisons liées à une consommation abusive d'alcool.

De plus, le jeu compulsif pourrait être à la hausse chez les personnes âgées. Une étude réalisée en Ontario a révélé que 6,4 p. cent des aînés qui s'adonnent au jeu courent le risque de devenir des joueurs compulsifs, et que 0,1 p. cent de cette population joue déjà à des niveaux problématiques. Une étude effectuée au Manitoba a permis de découvrir que 1,6 p. cent des joueurs âgés risquent de développer une dépendance au jeu et que 1,2 p. cent des aînés sont déjà des joueurs compulsifs[406]. Il n'existe au Canada que 12 programmes spécialisés dans le traitement des dépendances qui desservent approximativement 1 250 personnes âgées par année[407].

9.5.4 Les enfants et les jeunes

L'absence de mesures pour s'attaquer aux conséquences de la toxicomanie et du jeu compulsif chez les groupes vulnérables, et plus particulièrement les jeunes, entraîne d'énormes coûts pour le Canada sur le plan humain et sur le plan financier.

Les jeunes sont les plus touchés par les problèmes de santé mentale et de toxicomanie[408]. Les recherches ont démontré que la consommation chez les enfants et les jeunes est un critère de prévision d'un comportement criminel ultérieur[409]. Certains joueurs compulsifs ont signalé qu'ils avaient commencé à jouer dès l'âge de 10 ans[410]. Les enfants et les jeunes sont aussi vulnérables à la violence psychologique, physique

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405 *Ibid.*

406 C. Spencer (juin 2005), Alcohol and Seniors: Gambling Issues for Seniors — Links, Programs, Research and Resources. Voir : www.agingincanada.ca.

407 C. Spencer (juin 2005), mémoire présenté au Comité sénatorial permanent des affaires sociales, des sciences et de la technologie.

408 Statistique Canada (2002), Enquête sur la santé dans les collectivités canadiennes ; santé mentale et bien-être. Voir : www.statcan.ca.

409 C. Dowden (2003), L'efficacité du traitement de la toxicomanie chez les jeunes délinquants. Voir : www.canada.justice.gc.ca.

410 Youth Gambling International (2004), Youth Problem Gambling. Voir : www.education.mcgill.ca.

et sexuelle exercée par des personnes qui s'occupent d'eux et qui consomment de l'alcool ou des drogues[411].

> *Pour ce qui est de diagnostics précoces, [...] il est beaucoup plus facile de s'occuper des enfants lorsqu'ils sont encore tout jeunes. Le diagnostic précoce [...], dans [le domaine] de la toxicomanie, peut définitivement sauver une vie et un chagrin de toute une vie, non seulement pour le jeune concerné mais pour beaucoup d'autres. — Dave Rodney*[412]

L'absence de mesures pour s'attaquer aux conséquences de la toxicomanie et du jeu compulsif chez les groupes vulnérables, et plus particulièrement les jeunes, entraîne d'énormes coûts pour le Canada sur le plan humain et sur le plan financier. Dans un scénario selon lequel il faut « payer maintenant ou payer plus tard », l'indifférence à l'égard de ces groupes entraîne à la longue des coûts sociaux et des coûts de santé sans cesse croissants.

La consommation chez les enfants et les jeunes est un critère de prévision d'un comportement criminel ultérieur.

Le Comité recommande donc (en plus des recommandations du chapitre 14 concernant spécialement les Autochtones) :

43	**Que le gouvernement du Canada évalue les résultats des programmes actuels axés sur les problèmes de dépendance des membres des Premières nations, des Inuits et des Métis.** **Que les résultats de cette évaluation soient diffusés par le Centre d'échange des connaissances qui fera partie de la Commission canadienne de la santé mentale (voir le Chapitre 16) dans le but d'établir des modèles de traitement efficaces et d'élargir ces programmes de manière à accroître l'accès et à réduire les périodes d'attente.** **Que les provinces et les territoires élaborent et mettent en œuvre des services fondés sur des données probantes et destinés aux personnes marginalisées ainsi que des programmes de prévention primaire et secondaire pour les populations à risque, c'est-à-dire les femmes, les enfants et les jeunes, les aînés et les personnes ayant des troubles causés par l'alcoolisation fœtale.**

411 N. Trocme et al. (2005), Étude canadienne sur l'incidence des signalements de cas de violence et de négligence envers les enfants — 2003. Voir : www.phac-aspc.gc.ca/.

412 9 juin 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/21eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

9.6 RESPONSABILITÉ DU GOUVERNEMENT

Il faut également étudier la toxicomanie dans le contexte de la réglementation et de la taxation liée à l'alcool et au jeu (y compris les loteries provinciales), deux importantes sources de revenu[413]. De puissants intérêts privés interviennent également dans la vente d'alcool et dans le jeu. Après des années de négligence de la part du gouvernement, les défenseurs des personnes aux prises avec une dépendance sont découragés du peu d'investissement dans la prévention, la promotion de la santé et le traitement des victimes en regard des sommes énormes recueillies sous forme de taxes et de revenus tirés du jeu[414].

Après des années de négligence de la part du gouvernement, les défenseurs des personnes aux prises avec une dépendance sont découragés du peu d'investissement dans la prévention, la promotion de la santé et le traitement des victimes en regard des sommes énormes recueillies sous forme de taxes et de revenus tirés du jeu.

> *[...] Il faut bien reconnaître que nous ne nous attaquons pas au vrai problème. Abstraction faite du fait qu'il faudrait peut-être taxer davantage l'alcool, il n'en demeure pas moins que le gouvernement impose déjà beaucoup ce produit et que les recettes ainsi recueillies ne sont pas utilisées aux bonnes fins. Même si une part de ces recettes sert à des fins utiles, il faudrait ouvertement reconnaître que le gouvernement continue d'encourager des activités qui sont nocives comme le jeu. — Michel Perron*[415]

9.7 DE NOUVELLES IDÉES QUI FONCTIONNENT

Des progrès remarquables ont été faits pour aider les personnes aux prises avec une dépendance et une maladie mentale dans divers endroits au Canada. Les résultats obtenus sont prometteurs ou positifs et confirmés par la recherche. Ils peuvent contribuer à créer un système plus solide reposant sur des services intégrés de santé mentale et de traitement de la toxicomanie.

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413 En 2002-2003, les ventes d'alcool au Canada ont totalisé 15,4 milliards de dollars, dont 12,6 milliards de dollars pour la vente de bière. Les taxes sur l'alcool et le tabac représentent 2,5 p. cent de l'ensemble des recettes fiscales. Source : G. Thomas (2004), *Méfaits liés à l'alcool et politique régissant la consommation au Canada.* Voir : www.ccsa.ca. En 1999-2001, les recettes recueillies par le gouvernement grâce au jeu dans l'ensemble du Canada étaient de 5,7 milliards de dollars. Source : Canada West Foundation (2001), *Gambling in Canada 2001: Overview.* Voir : www.cwf.ca. En 2001, les ménages canadiens ont dépensé en moyenne 257 $ à la loterie. Source : www.cbc.ca/background/gambling.

414 Ontario Federation of Mental Health and Addiction Programs (2003), *Generating New Revenue to Support Addictions Services: A Behavioural Insurance Model.* Voir : www.ofcmhap.on.ca.

415 21 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/28ev-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

9.7.1 Le traitement intégré de troubles concomitants

La consommation abusive d'alcool ou de drogues peut masquer les symptômes d'une maladie mentale, mais chez les personnes dont on sait qu'elles souffrent de troubles mentaux, cette consommation peut aggraver les symptômes psychiatriques. En conséquence, les personnes souffrant de troubles concomitants[416] ont généralement des problèmes plus complexes et il est plus difficile de les aider parce qu'elles ont souvent des comportements plus dérangeants, acceptent moins bien le traitement et sont plus sujettes aux rechutes[417] que les personnes dont la maladie mentale n'est pas aggravée par la toxicomanie ou vice-versa.

Le système de santé mentale et le système de traitement de la toxicomanie ont mis du temps avant de reconnaître l'existence même de troubles concomitants. Habituellement, les personnes atteintes de ces troubles font la navette d'un service à l'autre pendant que les cliniciens et les spécialistes essaient de déterminer quel problème il faut traiter avant tout.

Le système de santé mentale et le système de traitement de la toxicomanie ont mis du temps avant de reconnaître l'existence même de troubles concomitants[418]. Habituellement, les personnes atteintes de ces troubles font la navette d'un service à l'autre pendant que les cliniciens et les spécialistes essaient de déterminer quel problème il faut traiter avant tout.

Après que les troubles concomitants ont été reconnus, un traitement appartenant à l'une des trois catégories suivantes a généralement été offert : le traitement *partiel* — axé sur l'un des problèmes, l'hypothèse étant que l'autre cesserait avec le temps; le traitement *séquentiel* — visant à résoudre un problème avant de traiter l'autre; le traitement *parallèle* — consistant en services distincts pour traiter les deux problèmes en même temps[419]. Les résultats ont été moins que satisfaisants, notamment en raison des différences entre les deux systèmes de traitement et leurs principes sous-jacents. Les gens ne s'y retrouvaient plus.

La documentation recommande également un traitement intégré, c'est-à-dire le traitement simultané des deux problèmes par une même équipe qui utilise des techniques et des principes compatibles.

La documentation sur les pratiques exemplaires recommande que les programmes de santé mentale et de traitement de la toxicomanie procèdent à un dépistage des troubles concomitants et, si ces troubles sont avérés, que les clients soient évalués en profondeur afin de recevoir le traitement qui convient. Elle recommande également un traitement intégré,

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416 L'expression « diagnostic mixte » (dual diagnosis) est utilisée au Royaume-Uni et aux États-Unis.

417 H. Stuart, au nom du Concurrent Disorders Champion Group (2002), *Concurrent disorders: An Integrated Service Delivery Plan for Southeastern Ontario*, présenté au Southeastern Ontario Mental Health Implementation Task Force et au Southeastern Ontario District Health Council.

418 B. Rush, *Concurrent Mental and Substance Use Disorders: Why Is Such "Double Trouble" So Important?*, mémoire présenté au Comité sénatorial permanent des affaires sociales, des sciences et de la technologie.

419 J. Negrete (2003), *Le traitement de la toxicomanie chez les personnes atteintes d'autres maladies psychiatriques*, mémoire présenté au Comité sénatorial permanent des affaires sociales, des sciences et de la technologie.

c'est-à-dire le traitement simultané des deux problèmes[420] par une même équipe qui utilise des techniques et des principes compatibles[421].

9.7.2 La formation en soutien social et familial

Cette approche offre une solution de remplacement à certaines interventions visant une confrontation, employées par des membres frustrés de la famille pour persuader un être cher de suivre un traitement. Il s'agit d'un modèle didactique, habituellement accompagné d'un cahier d'exercices, qui fait appel à divers aspects de la thérapie cognitivo-comportementale pour aider les familles et les amis d'une personne dépendante à trouver des moyens de rester en sécurité, à analyser les situations dans lesquelles la consommation abusive est plus susceptible de se produire, à utiliser le renforcement positif pour eux-mêmes et pour la personne dépendante et à adopter un mode de vie plus sain. La recherche a démontré que ce genre d'intervention minimale est très efficace pour inciter la personne ayant une dépendance, y compris le joueur compulsif, à entreprendre un traitement; cette approche a obtenu un taux de réussite de 64 p. cent auprès des personnes aux prises avec des problèmes de consommation d'alcool et de drogues, et sept joueurs compulsifs sur dix ont accepté de suivre un traitement[422] .

> *Plus la famille participe — c'est-à-dire les gens que le jeune considère comme sa famille, meilleures sont ses chances de s'en sortir. — Nancy Bradley*[423]

9.7.3 La réduction des méfaits

La réduction des méfaits vise à amoindrir les incidences sur la santé et les conséquences sociales de la consommation d'alcool et de drogues sans exiger que les personnes deviennent abstinentes. On peut rechercher l'abstinence à long terme, mais l'objectif à court terme est la consommation sécuritaire.

La réduction des méfaits vise à amoindrir les incidences sur la santé et les conséquences sociales de la consommation d'alcool et de drogues sans exiger que les personnes deviennent abstinentes. On peut rechercher l'abstinence à long terme, mais l'objectif à court terme est la consommation sécuritaire. Les caractéristiques de la réduction des méfaits sont : le *pragmatisme* — accepter qu'il est inévitable que des gens consomment de l'alcool et des drogues et que certaines personnes le feront de façon excessive; les *valeurs humaines* — la dignité et les droits du consommateur d'alcool ou de drogues sont respectés; l'*accent mis sur les méfaits* — la quantité consommée est d'une

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420 Seule exception : les lignes directrices sur les pratiques exemplaires (Rush, 2002) recommandent de traiter d'abord la toxicomanie chez les personnes souffrant de troubles anxieux et de l'humeur — un traitement intégré est toutefois conseillé dans le cas du syndrome de stress post-traumatique.

421 Centre de toxicomanie et de santé mentale (2002), *Meilleures pratiques — Troubles concomitants de santé mentale et de toxicomanie.* Voir : http://www.hc-sc.gc.ca/ahc-asc/pubs/drugs-drogues/bp_disorder-mp_concomitants/index_f.html.

422 Ontario Problem Gambling Research Centre, *Minimal Treatment Approaches for Concerned Significant Others of Problem Gamblers.* Voir : www.gamblingresearch.org/printdoc.sz?cid=123.

423 21 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/28cv-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

importance secondaire par rapport aux méfaits pouvant en résulter; la *hiérarchie des objectifs* — il faut d'abord répondre aux besoins les plus pressants[424].

9.7.3.1 Les programmes d'échange de seringues (PES)

Aucun établissement correctionnel ne dispense de matériel d'injection stérile aux détenus.

Au Canada, le premier programme non officiel d'échange de seringues a vu le jour à Toronto en 1987. D'autres PES officiels ont été mis en place à Toronto et à Vancouver en 1989. Aujourd'hui, il existe 30 PES au Canada. Toutes les prisons administrées par Service correctionnel du Canada fournissent aux détenus de l'eau de Javel pour désinfecter les seringues mais, en dépit de recommandations répétées visant l'instauration de PES, aucun établissement correctionnel ne leur dispense de matériel d'injection stérile[425].

Les PES font l'objet d'une exemption dans le *Code criminel* du Canada et dans la *Loi sur les aliments et drogues* conformément à laquelle la distribution d'accessoires facilitant la consommation de drogues est légale à condition qu'elle ait pour but de prévenir l'infection à VIH. Au départ, le gouvernement fédéral partageait les coûts avec les gouvernements provinciaux. De nos jours, les programmes sont mis en œuvre selon divers modèles de financement, notamment des partenariats fédéraux et provinciaux/municipaux. Le coût d'une trousse d'échange de seringue s'élève à un peu plus d'un dollar.

De nombreuses craintes ont été soulevées au sujet de ces programmes, mais d'après les témoignages, elles ne se sont pas confirmées :

- Les programmes d'échange de seringues ne donnent pas lieu à une prolifération d'aiguilles dangereuses jetées dans la collectivité. En fait, le nombre d'aiguilles rapportées dépasse le nombre d'aiguilles données.

- Les programmes d'échange de seringues n'ont pas attiré plus de trafiquants de drogues dans les quartiers où ils sont mis en œuvre.

- La police ne s'oppose pas à ces programmes — l'Association canadienne des chefs de police a adopté une résolution en faveur de la Stratégie canadienne sur le VIH/sida, y compris les programmes d'échange de seringues[426].

9.7.3.2 Les centres d'injection supervisés (CIS)

Les centres d'injection supervisés assurent l'échange de seringues, mais ils offrent en plus un endroit sécuritaire où consommer des drogues et recevoir des soins médicaux d'urgence, des services de santé de base, du counselling, des services d'aiguillage vers d'autres organismes, de l'information et l'intégration à des réseaux de soutien social de toxicomanes. Les CIS ont

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424 G. Thomas (2005), *Politiques et programmes de réduction des méfaits à l'intention des personnes ayant des démêlés avec le système de justice pénale,* Centre canadien de lutte contre l'alcoolisme et les toxicomanies. Voir : www.ccsa.ca.

425 *Ibid.*

426 Centre canadien de lutte contre l'alcoolisme et les toxicomanies (février 2004), *Foire aux questions sur les programmes d'échange de seringues (PES).* Voir : www.ccsa.ca.

généralement des règles internes relatives à la sécurité; ils peuvent par exemple interdire la consommation d'alcool, la violence et le trafic de drogues et n'accueillir que des toxicomanes du quartier qui ont 18 ans et plus.

Le seul CIS du Canada se trouve à Vancouver. Il fonctionne dans le cadre d'un projet de recherche scientifique de trois ans. Il a été établi en vertu de l'article 56 de la *Loi réglementant certaines drogues et autres substances,* qui permet au ministre fédéral de la Santé d'accorder une exemption relative à l'application de la Loi pour des raisons médicales ou scientifiques particulières. Quatre-vingt-dix pour cent des personnes qui fréquentent le CIS de Vancouver ont le virus de l'hépatite C, et 28 à 30 p. cent ont le VIH. Le CIS supervise 500 injections sécuritaires par jour[427].

9.7.3.3 Vin et bière dans les refuges

Certains itinérants refusent de fréquenter les refuges parce qu'ils ne peuvent y apporter leurs bouteilles d'alcool; d'autres boivent tout leur alcool avant d'entrer au refuge, ce qui cause par la suite des bagarres et des blessures pour le personnel et d'autres clients. Devant le problème de la violence dans les refuges et des personnes qui meurent de froid dans la rue, le personnel de quelques refuges de Toronto a commencé à adopter une approche de réduction des méfaits qui consiste à donner aux alcooliques un verre de bière ou de vin à une fréquence d'une heure ou deux pendant le séjour au refuge.

L'Annex Harm Reduction Program, un programme satellite de l'hôpital St. Michael de Toronto, qui s'adresse aux hommes vivant au refuge Seaton[428], offre désormais des traitements médicaux et des services d'aiguillage vers des services de traitement de la toxicomanie et d'hébergement. Les résultats préliminaires d'une évaluation démontrent que les accidents et les blessures liés à l'alcool sont en baisse, que les hommes boivent de l'alcool sous forme moins nocive (que le Lysol, le rince-bouche ou l'alcool à friction) et qu'ils reçoivent de meilleurs soins médicaux. Certains ont réduit leur consommation d'alcool, d'autres ont entrepris un traitement, tandis que d'autres encore se sont trouvé un logement stable et occupent un emploi[429].

Les participants reçoivent toutes les heures un verre de vin fait maison qui est dilué progressivement. L'évaluation du programme indique une baisse des visites à l'urgence, des hospitalisations et des appels à des ambulanciers.

À Ottawa, le refuge des Bergers de l'espoir a instauré un programme de réduction de méfaits grâce à une subvention de l'Initiative de partenariats en action communautaire (IPAC). Ce programme accueille dix personnes à la fois, 24 heures sur 24 et sept jours sur sept, et il a une liste d'attente d'une trentaine de noms. Les participants reçoivent toutes les heures un verre de vin fait maison qui est dilué progressivement. L'évaluation du programme indique une baisse des visites à l'urgence, des hospitalisations et des appels à des ambulanciers. Les

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427 Centre canadien de lutte contre l'alcoolisme et les toxicomanies (juillet 2004), *Foire aux questions sur les centres d'injection supervisés (CIS).* Voir : www.ccsa.ca.

428 La maison Seaton est un refuge pour hommes.

429 P. Wysong (novembre 2002), « Homecare for the Homeless », *Medical Post*, vol. 38, nº 40. Voir : www.medicalpost.com.

personnes qui ont terminé le programme ont obtenu un logement stable, évité la prison et suivi un traitement[430].

9.7.4 Le tribunal de traitement de la toxicomanie (TTT)

Le ministère fédéral de la Justice a financé un premier tribunal de traitement de la toxicomanie à Toronto en 1998 et un deuxième à Vancouver en 2001. Ces tribunaux identifient les délinquants à faible risque dont le principal problème est la consommation abusive de drogues et à qui il serait préférable d'imposer un traitement plutôt que l'incarcération. Ces délinquants, notamment des jeunes, se voient offrir de l'éducation antidrogue, une préparation à l'emploi et un traitement en santé mentale s'ils assument la responsabilité des infractions qu'ils ont commises. Les peines se limitent souvent à du travail communautaire; les chefs d'accusation peuvent également être retirés si le délinquant suit le traitement au complet et obtient de bons résultats. En mai 2003, le gouvernement fédéral a engagé 23 millions de dollars sur cinq ans pour l'établissement d'autres TTT[431].

9.7.5 Programmes de jour et programmes de désintoxication à domicile

La stratégie la plus rentable d'intervention précoce pour l'alcoolisme est une séance de conseils dispensés par un médecin de premier recours et un suivi assuré par une infirmière[432]. Les progrès accomplis grâce à la recherche sur les services de désintoxication ont aussi démontré que les personnes ayant une dépendance physiologique à l'alcool ou aux drogues peuvent suivre avec succès un programme de désintoxication qui leur offre un soutien infirmier à domicile ou dans le cadre d'un programme de jour[433]. L'idée de créer des équipes locales de consultation et de traitement de l'alcoolisme a germé au Royaume-Uni et ailleurs par suite des longues listes d'attentes pour l'hospitalisation. Des études sur les coûts relatifs ont indiqué que le coût des soins dispensés à l'hôpital est approximativement dix fois plus élevé que celui des soins communautaires et que les résultats sont similaires[434]. Il faut toutefois noter que des services de désintoxication en résidence sont quand même nécessaires pour les sans-abri.

> *Ainsi, dans le service auquel j'ai collaboré au Royaume-Uni, une infirmière communautaire réalisait en un an autant de programmes de désintoxication à domicile pour alcooliques que l'hôpital général, qui*

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430 Alderson-Gill & Associates Consulting Inc. (2002), *Évaluation — Initiative nationale pour les sans-abri. Étude de cas d'un projet pour les sans-abri : Bergers de l'espoir, Programme de réduction des méfaits*, Ottawa (Ontario). Voir : www.homelessness.gc.ca/projects/casestudies/docs/ottawa/shepherds_f.pdf.

431 La santé mentale, ça nous concerne! Feuillet d'information *Justice et santé mentale,* 2003. Voir : http://www.cmha.ca/data/1/rec_docs/521_justiceFR.pdf.

432 T. Stockwell, assisté de J. Sturge (septembre 2005), mémoire présenté au Comité sénatorial permanent des affaires sociales, des sciences et de la technologie.

433 N. Brunemeyer (mars 2004), « Addictions Services Redesign at Vancouver Coastal Health », *Four Pillars News*, vol. II, nº 1. Voir : www.city.vancouver.bc.ca/fourpillars/newsletter.

434 M. Hayashida, A. Altman, A. McLellan, C. O'Brien, J. Purtil, J. Volpicelli, A. Pahelson et C. Hall (1989), « Comparative Effectiveness of Inpatient and Outpatient Detoxification of Patients with Mild-to-moderate Alcohol Withdrawal Symptoms », *New England Journal of Medicine*, vol. 320, nº 6, p. 358-365.

constituait l'autre grand fournisseur de services de la région. — Tim Stockwell[435]

La stratégie la plus rentable d'intervention précoce pour l'alcoolisme est une séance de conseils dispensés par un médecin de premier recours et un suivi assuré par une infirmière. Un programme de désintoxication leur offre un soutien infirmier à domicile dans le cadre d'un programme de jour.

À l'exception du traitement des troubles concomitants et du programme de formation en soutien social et familial, les tendances présentées dans cette partie restent controversées, surtout celles qui concernent la réduction des méfaits. La société juge sévèrement ceux qui, selon elle, font de mauvais choix. Le principe de la réduction des méfaits remet en question les perceptions parce qu'il prône un modèle horizontal, d'adulte à adulte, qui vise à assurer la plus grande sécurité possible pour tous, y compris la société dans son ensemble, tout en préservant la dignité et l'espoir pour les personnes touchées.

Compte tenu de ces progrès, le Comité recommande :

44	**Qu'une partie des fonds consacrés au traitement de la toxicomanie qui proviendront du Fonds de transition en santé mentale soit affectée à l'élaboration de traitements intégrés de troubles concomitants, de même qu'à la recherche et à l'échange du savoir à cet égard.** **Que les médecins de famille reçoivent, dans le cadre des programmes de médecine et de perfectionnement professionnel, de la formation visant à diagnostiquer l'ensemble des troubles causés par l'alcoolisation fœtale (ETCAF).** **Que les médecins de famille reçoivent la formation appropriée sur les techniques d'intervention brève et d'entrevue pour reconnaître la consommation problématique conduisant à la toxicomanie.**

9.8 ÉTAPES MENANT À L'INTÉGRATION

9.8.1 Miser sur les points communs

Les services de santé mentale et les services de traitement de la toxicomanie ont toujours évolué séparément, ayant chacun son propre objectif. La toxicomanie et la maladie mentale sont deux problèmes très complexes. Les services relatifs à l'une et à l'autre doivent agir sur de multiples facteurs et tenir compte d'une foule de conséquences personnelles et sociales. Les résultats ne sont pas garantis même quand le meilleur soutien et les traitements les plus efficaces sont offerts. Les deux genres de services sont fondés sur des théories différentes quant aux causes, aux effets et à l'aide à apporter. Ils ont toutefois des aspects convergents,

[435] 21 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/28ev-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

notamment la publication de documents sur les pratiques exemplaires et le traitement des troubles concomitants ainsi que l'établissement de certains services mixtes.

> *En 13 ans d'expérience, j'ai constaté que les chasses gardées ont plus ou moins tendance à s'estomper. Dans mon milieu, certaines personnes disent qu'il peut y avoir des conflits au niveau provincial mais qu'au niveau communautaire, tout le monde s'entend assez bien. — Jeff Wilbee*[436]

9.8.1.1 Le rétablissement

Le rétablissement offre une lueur d'espoir depuis 1935, année où le mouvement d'entraide le mieux connu, Alcooliques Anonymes, a été fondé. Dans le milieu de la toxicomanie, le rétablissement est défini comme un processus permanent pour bien vivre malgré les combats à livrer. Au cours des 20 dernières années, le système de santé mentale, guidé par les personnes aux prises avec la maladie mentale, a commencé à faire du rétablissement[437] son concept déterminant. Toutefois, les théories de traitement professionnel ne reposent pas encore pleinement sur ce concept.

Dans le milieu de la toxicomanie, le rétablissement est défini comme un processus permanent pour bien vivre malgré les combats à livrer. Au cours des 20 dernières années, le système de santé mentale, guidé par les personnes aux prises avec la maladie mentale, a commencé à faire du rétablissement[1] son concept déterminant.

9.8.1.2 L'entraide et le soutien par les pairs

Le traitement de la toxicomanie a été fondé sur l'entraide, mais au fil du temps, il a pris la forme de services professionnels. Des établissements d'enseignement supérieur offrent aujourd'hui des spécialisations en toxicomanie qui reçoivent la reconnaissance professionnelle et l'accréditation. De nos jours, la plupart des services de traitement de la toxicomanie ont une solide direction professionnelle. Le système de santé mentale actuel a commencé par une spécialité médicale, la psychiatrie, qui s'est ramifiée au cours du siècle dernier en diverses professions telles que les infirmières psychiatriques et les travailleurs sociaux. Le mouvement d'entraide en santé mentale est relativement nouveau et ses promoteurs ont dû réclamer fermement sa place dans le système dirigé majoritairement par des professionnels. Heureusement, les fournisseurs de services de santé mentale et de traitement de la toxicomanie en sont venus à comprendre et à apprécier l'entraide et le soutien par les pairs tout en continuant de reconnaître l'importance d'une présence professionnelle.

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436 21 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/28ev-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

437 Voir le chapitre 3 pour obtenir des précisions sur la façon dont le système de santé mentale définit le rétablissement.

Nous avons tout de même des pairs professionnels et je pense que personne ne peut mieux donner de l'espoir à nos consommateurs que ces personnes, qui sont elles-mêmes passées par là. Il n'y a pas de meilleurs porte-parole. Il y aura toujours des pairs professionnels, mais leur proportion [de soutien par les pairs par rapport aux soins professionnels] change en raison du genre de service que nous fournissons. — Greg Purvis[438]

9.8.1.3 Les services communautaires non médicaux

Issus des activités d'entraide, les services de traitement de la toxicomanie ont toujours été axés sur une approche communautaire et non médicale.

Issus des activités d'entraide, les services de traitement de la toxicomanie ont toujours été axés sur une approche communautaire et non médicale. Même si certaines personnes doivent de temps à autre faire l'objet d'une intervention médicale ou d'une évaluation psychiatrique et recevoir un diagnostic et des médicaments, on peut dire que, dans l'ensemble, les services offerts aux toxicomanes sont de nature communautaire et non médicale.

Les services communautaires de santé mentale se sont développés par suite de la désinstitutionnalisation entreprise à la fin des années 1960.

Les services communautaires de santé mentale se sont développés par suite de la désinstitutionnalisation entreprise à la fin des années 1960. Partout au Canada, les gouvernements ont continué à fermer des lits psychiatriques. Même si l'investissement dans les services communautaires a pris trop de temps à se concrétiser, les décideurs et les gens sur le terrain sont déterminés à instaurer un système fondé essentiellement sur des services communautaires non médicaux.

9.8.1.4 Les principaux déterminants de la santé

Les gestionnaires et les fournisseurs de services de santé mentale et de traitement de la toxicomanie sont très conscients de l'importance des principaux déterminants de la santé dans la prévention des problèmes ou dans l'atténuation de leurs effets. Un logement sécuritaire et abordable, l'emploi, l'éducation, un soutien du revenu suffisant et la protection contre la violence sont importants pour la santé et le bien-être de tous les Canadiens; ils sont essentiels à la survie des personnes aux prises avec la maladie mentale et la toxicomanie.

9.8.1.5 L'intervention précoce

L'intervention précoce en cas de psychose est peut-être le traitement intégré le plus prometteur dans le domaine de la santé mentale.

Les services de l'un et de l'autre secteur reconnaissent qu'il est important de cerner rapidement les problèmes pour intervenir ensuite de la façon la moins déstabilisante et la moins lourde de conséquences possible. Assurer des grossesses en santé, appuyer les parents à risque dans l'acquisition de compétences, mettre l'accent sur le

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438 21 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/28ev-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

développement de la petite enfance et aider les enfants et les adolescents qui commencent à avoir des problèmes liés à la consommation abusive d'alcool ou de drogues, toutes ces mesures permettent de sauver des vies et de prévenir une vie de dépendance envers de coûteux programmes sociaux et de santé.

L'intervention précoce en cas de psychose est peut-être le traitement intégré le plus prometteur dans le domaine de la santé mentale. S'ils sont identifiés rapidement et reçoivent de faibles doses de médicaments pendant de courtes périodes, les jeunes à risque peuvent éviter l'hospitalisation, la perte de l'accès à l'éducation, le chômage et la perte du soutien social et familial.

La concurrence que se livrent le secteur du traitement de la toxicomanie et celui de la santé mentale pour obtenir de maigres ressources est insensée. Elle ne fait qu'accentuer les différences et décourager la collaboration.

> *Sénateur, vous avez parlé d'éléments manquants. Ce qui m'a tout de suite frappé, c'est le nombre de fois que j'ai lu ou entendu des exposés sur les traumatismes infantiles, la violence et la toxicomanie dont sont victimes les enfants. Je ne veux pas simplement vous parler de la façon d'améliorer le système de traitement mais plutôt de réduire la demande pour ce système. Si l'on fait davantage pour les enfants qui ont des problèmes, on réduira autant les pressions sur le système de traitement de la toxicomanie que tout ce que l'on peut faire directement pour ce système. — Jon Kelly*[439]

La concurrence que se livrent le secteur du traitement de la toxicomanie et celui de la santé mentale pour obtenir de maigres ressources est insensée. Elle ne fait qu'accentuer les différences et décourager la collaboration. Il semble toutefois qu'à la longue, de nombreux points en commun sont apparus. Il faut dorénavant que les services de traitement de la toxicomanie et les services de santé mentale mettent en place des mécanismes intégrés reposant sur leurs intérêts et leurs points de vue communs et, surtout, axés sur les avantages accrus que peuvent en tirer les personnes touchées.

9.8.2 L'approche graduelle

Dans un document de politique intitulé *Every Door is the Right Door,* la Colombie-Britannique propose l'élaboration d'un modèle d'interventions du système de santé qui est axé sur la collaboration et qui transcende les domaines de la santé de la population, de la promotion de la santé, de la réduction des méfaits et du renforcement des capacités de la collectivité. Le modèle vise à aider les responsables locaux de la santé à planifier, à mettre en œuvre et à évaluer un

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[439] 21 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/28cv-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

système intégré et fondé sur des preuves pour les toxicomanes et les personnes aux prises avec la maladie mentale[440].

Dans son document *Building Capacity: A Framework for Serving Albertans Affected by Addiction and Mental Health Issues*, l'Alberta précise qu'elle vise à améliorer les services offerts aux personnes ayant des troubles concomitants et à en accroître l'accès grâce à des partenariats de services et au partage des soins, les psychiatres donnant généralement des conseils aux médecins de premier recours. Le cadre met également l'accent sur l'information, la prévention et l'intervention précoce dans le cas des personnes dont la situation n'est pas encore grave[441].

> *[La] position [du CCLAT] est on ne peut plus claire. Nous appuyons pleinement l'élaboration d'un nouveau modèle, qui offrira des services coordonnés aux Canadiens en matière de santé mentale et de toxicomanie, et nous estimons que, dans certaines circonstances, un tel modèle nécessite une intégration stratégique des diverses méthodes de traitement des problèmes de santé mentale et de toxicomanie. — Michel Perron*[442]

9.8.2.1 Le modèle du quadrant

Le modèle du quadrant est bien connu des fournisseurs de services de traitement de la toxicomanie. Il a été adopté en tant qu'outil de réflexion aidant à conceptualiser l'intégration d'une manière qui respecte les différences entre le domaine de la santé mentale et celui du traitement de la toxicomanie tout en offrant des possibilités d'intégration qui peuvent être rapidement mise à exécution[443].

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440 Ministère des Services de santé de la Colombie-Britannique (mai 2004), *Every Door Is the Right Door: A British Columbia Planning Framework to Address Problematic Substance Use and Addiction.* Voir : http://www.healthservices.gov.bc.ca/mhd/pdf/framework_for_substance_use_and_addiction.pdf.

441 Alberta Alcohol and Drug Abuse Commission (juillet 2005), *Building Capacity: A Framework for Serving Albertans Affected by Addiction and Mental Health Issues.* Voir : www.aadac.com.

442 21 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/28ev-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

443 W. Skinner (septembre 2005), mémoire présenté au Comité sénatorial permanent des affaires sociales, des sciences et de la technologie.

TOXICOMANIE		
↑ Élevé	**Quadrant 3** Niveau élevé de problèmes liés à la toxicomanie et faible niveau de maladie mentale SOINS SPÉCIALISÉS EN MATIÈRE DE DÉPENDANCE	**Quadrant 4** Niveau élevé de problèmes liés à la toxicomanie et niveau élevé de maladie mentale SOINS SPÉCIALISÉS ET INTÉGRÉS EN MATIÈRE DE TROUBLES CONCOMITANTS
Faible ↓	**Quadrant 1** Faible niveau de problèmes liés à la toxicomanie et faible niveau de maladie mentale SOINS PRIMAIRES	**Quadrant 2** Faible niveau de problèmes liés à la toxicomanie et niveau élevé de maladie mentale SOINS SPÉCIALISÉS EN MATIÈRE DE SANTÉ MENTALE
	← Faible — Élevé →	
	MALADIE MENTALE	

Les personnes ayant un faible niveau de maladie mentale et de toxicomanie (quadrant 1) forment de loin le segment le plus important de la société qui demandera le plus fréquemment l'aide d'un médecin de premier recours. Le modèle du quadrant propose que les services de traitement de la toxicomanie et les services de santé mentale deviennent *compétents en matière de troubles concomitants,* c'est-à-dire qu'ils soient en mesure de reconnaître les problèmes de santé mentale et de toxicomanie et d'intervenir dans les deux cas. Seules les personnes peu nombreuses visées par le quadrant 4 doivent recevoir des *services spécialisés en matière de troubles concomitants.*

Le modèle du quadrant ne privilégie pas un système plutôt qu'un autre. Il ne présuppose pas non plus la fusion de l'administration et des services des deux domaines ni la suppression de programmes spécialisés. Des mécanismes intégrés pourraient être mis en place à l'échelon local et comprendre : des ententes conclues entre les organismes de santé mentale et ceux de traitement de la toxicomanie au sujet de la prestation de services; la nomination d'organismes locaux de direction pour s'occuper de l'admission, de l'évaluation et de l'aiguillage; des outils de communication facilitant la transmission sécuritaire des renseignements personnels sur la santé; l'utilisation de la technologie à distance pour offrir des services de santé mentale et de traitement de la toxicomanie ainsi que des services spécialisés aux régions éloignées ou mal desservies.

9.8.2.2 Une perspective nationale commune

Le domaine du traitement de la toxicomanie a pu profiter d'une Stratégie canadienne antidrogue (mai 2003), d'une enquête nationale sur la consommation d'alcool et de drogues (*Enquête sur les toxicomanies au Canada*, novembre 2004) et du leadership permanent du Centre

canadien de lutte contre l'alcoolisme et les toxicomanies (CCLAT). Un Cadre d'action national sur la consommation et l'abus d'alcool et de drogues est en cours d'élaboration par suite d'un vaste processus de consultation au terme duquel s'est tenu une conférence nationale sur la toxicomanie en juin 2005[444].

Le 7 juin 2005, la Chambre des communes a adopté une motion réclamant, entre autres, une stratégie nationale sur la santé mentale[445]. Cette motion ouvre la voie à l'établissement d'une stratégie nationale sur la santé mentale, la maladie mentale et la toxicomanie qui doit intégrer, sans les subsumer, les activités nationales en cours dans le domaine du traitement de la toxicomanie.

9.8.2.3 Perspective à long terme

L'expérience de ceux qui ont entrepris l'intégration démontre que le processus est difficile en dépit de l'engagement des intervenants sur le terrain. Il faudra du temps, du leadership et des fonds pour créer des relations étroites entre les services de traitement de la toxicomanie et ceux de santé mentale, mais les premiers pas à cet égard doivent être faits sans plus attendre.

> *Si les gens ont la liberté de parler, de discuter, d'être en désaccord et d'harmoniser ensuite leurs vues, on encourage beaucoup plus l'adhésion. […] Lorsque les gens commenceront à être sensibilisés et à comprendre le processus, il leur faudra des ressources et des possibilités, sinon on aura fait beaucoup de bruit pour rien. Il faut que les ressources soient assurées avant de lancer un programme de sensibilisation. À défaut de cela, on va au devant des désaccords et de l'échec. En outre, il faut prévoir les résultats souhaités, les mesurer et en informer les intéressés. Il n'y a rien de tel que des résultats positifs pour mobiliser les intervenants du domaine de la santé mentale et des toxicomanies en faveur d'un nouveau*

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444 Le Cadre national a défini : des questions (sensibilisation accrue aux problèmes liés à la consommation abusive d'alcool et de drogues, réduction de la consommation problématique d'alcool, prévention de la consommation problématique de médicaments, examen de stratégies d'application de la loi et examen de l'ensemble des troubles causés par l'alcoolisation fœtale); une infrastructure de soutien (soutien du perfectionnement de l'effectif, accès accru aux services, mise en œuvre d'un programme national de recherche et transfert du savoir et actualisation des cadres législatif, réglementaire et stratégique); les populations clés (enfants et adolescents, populations du Nord, Premières nations, Inuits et Métis, et délinquants).

445 La motion se lit comme suit : « Que, puisqu'il faut élaborer dès maintenant une stratégie nationale pour réduire les coûts humains et économiques de plus en plus lourds du cancer, des cardiopathies et des ***maladies mentales***, la Chambre demande au gouvernement de financer intégralement et de mettre en œuvre, en symbiose avec les provinces et tous les intervenants, la Stratégie canadienne de lutte contre le cancer ainsi que ***d'élaborer et d'appliquer sans délai une stratégie nationale d'ensemble sur les maladies mentales et les cardiopathies, le Canada étant un des rares pays développés à ne pas avoir de plan d'action national pour réduire l'incidence des maladies mentales et des maladies du cœur.*** » [C'est nous qui soulignons.]

processus. Les gens souhaitent réussir et offrir les meilleurs services possibles à leurs clients. — Greg Purvis[446]

Les services de traitement de la toxicomanie au Canada sont fragmentés et souffrent d'un sous-financement chronique, ce qui ne leur permet pas de répondre efficacement aux besoins des toxicomanes et de leur famille. La culture de cloisonnement entre les services de santé mentale et les services de traitement de la toxicomanie a ajouté à la frustration. Un certain nombre de points communs importants peuvent toutefois constituer un point de départ logique à l'intégration. Les membres du Comité ont appris que le mode privilégié d'intégration consiste à préserver ce qui est propre à chaque domaine tout en misant sur les valeurs communes, le dialogue et les terrains d'entente évidents.

Le mode privilégié d'intégration consiste à préserver ce qui est propre à chaque domaine tout en misant sur les valeurs communes, le dialogue et les terrains d'entente évidents.

Le Comité recommande donc :

45	**Que la Commission canadienne de la santé mentale (voir le Chapitre 16) établisse des partenariats avec les organismes nationaux de traitement de la toxicomanie et déploie des efforts pour atteindre l'objectif ultime d'intégration des secteurs de la maladie mentale et du traitement de la toxicomanie.**

9.9 CONCLUSION

Les progrès réalisés au niveau du savoir scientifique ont donné lieu à des interventions qui produisent des résultats positifs chez les toxicomanes. Les témoins qui se sont présentés devant le Comité ont insisté sur la nécessité d'intégrer les traitements dispensés aux personnes ayant à la fois des problèmes de santé mentale et des problèmes d'alcool ou de drogues, c'est-à-dire des troubles concomitants. Nous appuyons cette recommandation.

Les témoins qui se sont présentés devant le Comité ont insisté sur la nécessité d'intégrer les traitements dispensés aux personnes ayant à la fois des problèmes de santé mentale et des problèmes d'alcool ou de drogues, c'est-à-dire des troubles concomitants.

Très peu de toxicomanes et de membres de leur famille ont témoigné. Le Comité souligne le courage de ceux qui l'ont fait. Nous entendons favoriser une solide présence de clients du secteur du traitement de la toxicomanie et de membres de leur famille.

Nous demandons un investissement soutenu dans le but de réduire les effets de la consommation abusive de substances légales sur la santé et le bien-être des Canadiens.

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[446] 21 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/28ev-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

Les personnes qui ont témoigné devant le Comité ont fait comprendre on ne peut plus clairement les problèmes liés à la dépendance à des substances légales et aux longues listes d'attente avant d'obtenir de l'aide. Nous demandons un investissement soutenu dans le but de réduire les effets de la consommation abusive de substances légales sur la santé et le bien-être des Canadiens.

Le jeu est une importante source de revenus pour les gouvernements, mais beaucoup de gens jouent de façon compulsive et moins de personnes que prévu demandent de l'aide. Ce problème caché commence seulement à apparaître; il ne faut pas qu'il soit passé sous silence et qu'il s'ensuive un manque de vigilance à cet égard. Les gouvernements doivent aider les victimes du jeu.

Les gouvernements doivent aider les victimes du jeu.

Le Comité demande l'établissement de stratégies efficaces d'action sociale et de prévention visant tout spécialement les personnes les plus à risque.

Les arguments en faveur de la réduction des méfaits ont convaincu le Comité. Les diverses approches, qui ont prouvé qu'elles pouvaient atténuer la souffrance, ont souvent été élaborées par des fournisseurs de services de première ligne qui déploient de l'ingéniosité pour résoudre les problèmes auxquels leurs clients et eux-mêmes sont confrontés quotidiennement.

Les populations vulnérables, soit les Autochtones, les jeunes, les aînés et les femmes, sont touchées de façon disproportionnée par les conséquences de la toxicomanie et du jeu compulsif. Nous avons été particulièrement ébranlés par la tragédie du syndrome d'alcoolisation fœtale, une anomalie congénitale évitable. Le Comité demande l'établissement de stratégies efficaces d'action sociale et de prévention visant tout spécialement les personnes les plus à risque.

Les arguments en faveur de la réduction des méfaits ont convaincu le Comité.

Le Comité a été impressionné par le nombre élevé de témoins qui appuient l'intégration des services de santé mentale et des services de traitement de la toxicomanie. Nous avons appris que les toxicomanes et leur famille ne comprennent rien aux divergences et aux débats qui peuvent préoccuper les fournisseurs de services et les décideurs. Ce qu'ils veulent, c'est obtenir de l'aide immédiatement. Heureusement, le Comité a appris qu'il existe de nombreux points au sujet desquels les services de traitement de la toxicomanie et les services de santé mentale s'entendent et sur lesquels il est possible de miser comme mécanismes d'intégration.

CHAPITRE 10:
ENTRAIDE ET SOUTIEN PAR LES PAIRS

10.1 INTRODUCTION

> *L'initiative personnelle apporte un soutien psychologique et de l'aide pratique. C'est le genre d'aide que l'on ne peut pas retrouver chez un médecin. Pour une personne qui souffre de maladie mentale ou qui en est sortie, rien ne vaut mieux que de se faire dire : « Je comprends ce que vous ressentez, je vous accompagne sur le chemin de la guérison. »*
> *—Linda Bayers*[447]

Les gens touchés et leur famille se tournent de plus en plus vers l'entraide et le soutien par les pairs pour remplacer les services hospitaliers, communautaires et professionnels ou y suppléer.

Au cours de ses nombreuses audiences publiques, le Comité a très souvent entendu le témoignage de personnes ayant une maladie mentale ou une toxicomanie et de membres de leur famille qui étaient déçus par le manque d'accès aux services et démoralisés par le manque d'espoir qu'évoque le traitement des maladies mentales et des toxicomanies au Canada. Tout en reconnaissant la valeur de l'aide professionnelle, les gens touchés et leur famille se tournent de plus en plus vers l'entraide et le soutien par les pairs pour remplacer les services hospitaliers, communautaires et professionnels ou y suppléer.

Le programme d'entraide le plus connu, Alcooliques Anonymes (AA), avait commencé en 1935. Quelques années plus tard, en 1937, un médecin, Abraham Low, a fondé l'organisation Recovery Inc. à Chicago, pour essayer de répondre en particulier aux besoins des personnes ayant une maladie mentale. Aujourd'hui, l'organisation maintient ses services strictement bénévoles partout en Amérique du Nord (www.recovery-inc.org). De même, l'organisation GROW, établie à Sydney, en Australie, en 1957, aide des milliers de membres en se fondant sur sa version d'un programme en 12 étapes et sur une philosophie « de bienveillance, d'amitié et d'entraide » (www.grow.net.au).

Au Canada, le premier service parallèle de santé mentale basé sur l'entraide, la Vancouver Mental Patients' Association (MPA), a vu le jour en 1971. L'Association existe encore, sous le nom de Motivation, Power and Achievement (MPA) (www.vmpa.org).

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447 10 mai 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/15evc-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

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Programme national de soutien par les pairs à l'intention des membres actuels des Forces canadiennes et des anciens militaires (www.osiss.ca). Ce programme unique en son genre, lancé en février 2002, fait partie du projet de soutien social des victimes du stress opérationnel. Il a permis d'aider 1 400 personnes et leur famille grâce à des renvois effectués au rythme d'un par jour. Établi dans 12 sites, le programme emploie 20 travailleurs de soutien des pairs ayant suivi une formation spéciale après avoir été eux-mêmes victimes d'un traumatisme lié au stress opérationnel. Au besoin, une équipe professionnelle est disponible pour des consultations. Les membres de la famille peuvent s'adresser à six sites répartis dans les différentes régions du pays. Le rôle des travailleurs de soutien des pairs est double : aider d'autres à surmonter un traumatisme dû au stress opérationnel et s'occuper de leur propre traumatisme. Ce modèle non médical a été présenté à des auditoires du Canada et de l'Australie ainsi qu'à Berlin. L'objectif du programme est « d'offrir le meilleur soutien possible par les pairs aux hommes et aux femmes des Forces canadiennes, qui continuent à participer à un nombre toujours croissant d'opérations exigeantes partout dans le monde » (général Ray Henault, chef d'état-major de la Défense, 2002). « Le soutien par les pairs sauve des vies tous les jours », a dit le lieutenant-colonel Stéphane Grenier, directeur du projet.

10.2 ENTRAIDE ET SOUTIEN PAR LES PAIRS: POURQUOI?

Les personnes ayant une maladie mentale et les membres de leur famille parlent des nombreux messages négatifs de la société et des professionnels de la santé, qui font obstacle à la guérison.

> *Dans la société d'aujourd'hui, la stigmatisation liée à la maladie mentale demeure une plaie. Nous ressentons cette stigmatisation tous les jours de notre vie... Au travail, on nous oublie quand vient le temps des promotions... Les compagnies d'assurance nous harcèlent en contestant la réalité de notre maladie pour pouvoir cesser de verser nos prestations d'invalidité... À l'hôpital, nous devons attendre pendant des heures dans la salle des urgences ou rentrer chez nous désespérés parce que notre cas n'est pas jugé prioritaire. —Frank Dyck*[448]

10.2.1 Trouver un endroit où l'on peut s'identifier à d'autres

Selon les personnes ayant une maladie mentale, l'aspect le plus pénible de leur situation découle non de la maladie elle-même, mais de la façon dont les autres les traitent.

Selon les personnes ayant une maladie mentale, l'aspect le plus pénible de leur situation découle non de la maladie elle-même, mais de la façon dont les autres les traitent. Les préjugés et la discrimination prennent de multiples formes : mépris des droits, ostracisme, perte des amis, parfois même rejet par la famille et, dans beaucoup de cas, perte du logement et de l'emploi. Quelque 34 p. 100 des participants aux consultations en ligne du Comité ont signalé qu'eux-mêmes ou d'autres gens qu'ils connaissaient avaient été renvoyés par un employeur ou avaient vu rejeter leur

[448] Dyck, F. (2 juin 2005), notes pour un exposé préparé en vue des audiences du Comité sénatorial permanent des affaires sociales, des sciences de la technologie.

demande d'emploi à cause d'une maladie mentale, tandis que 21 p. 100 ont dit qu'on avait refusé de leur louer un logement[449].

> *Si nous nous cassons une jambe, nous savons que nous devons aller à la salle des urgences. Mais si nous avons un accès de panique, si nous avons des pensées suicidaires, nous ne savons pas à qui nous adresser. On nous dit d'aller à la salle des urgences, mais si le personnel médical ne voit pas de blessures, il nous renvoie chez nous. —Anonyme*

Les familles doivent elles aussi supporter le fardeau de la stigmatisation.

Les familles doivent elles aussi supporter le fardeau de la stigmatisation. Et, ce qui est pire, il arrive aux personnes ayant une maladie mentale et à leur famille d'intérioriser les attitudes négatives de la société et de se tenir elles-mêmes responsables de leur propre marginalisation. Les gens ayant une maladie mentale disent qu'ils doivent aussi affronter « les préjugés et la discrimination dans le système de santé mentale lui-même », ce système vers lequel ils se tournent pour obtenir de l'aide quand ils se sentent très vulnérables[450]. Lors de la consultation en ligne du Comité, 22 p. 100 des répondants ont signalé que le personnel médical avait manqué de respect à leur égard ou ne s'était pas soucié d'un trouble physique qu'ils avaient mentionné à cause de leur maladie mentale ou de leur toxicomanie[451]. La recherche révèle d'ailleurs — ce qui ne surprend pas — que deux tiers des personnes ayant une toxicomanie ou une maladie mentale n'essaient même pas d'obtenir de l'aide[452].

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L'entraide et le soutien par les pairs compensent la stigmatisation en donnant aux gens une place où ils sont bien accueillis et se sentent en sécurité.

L'entraide et le soutien par les pairs compensent la stigmatisation en donnant aux gens une place où ils sont bien accueillis et se sentent en sécurité. Cela est particulièrement important dans le cas des groupes mal servis par le système traditionnel de santé mentale.

> *Avec le temps, il est apparu qu'il n'était peut-être pas possible, ni désirable, de promouvoir la sensibilisation aux réalités culturelles chez les fournisseurs de services de santé mentale conventionnels, avec ce but espéré de les voir prendre eux-mêmes la responsabilité de fournir ce type de*

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449 H. Chodos, N. Pogue et T. Riordan, 2005, Consultation électronique en matière de services de santé mentale, de maladie mentale et de toxicomanie, phase 1, Service d'information et de recherche parlementaires, Bibliothèque du Parlement.

450 Comité sénatorial permanent des affaires sociales, des sciences de la technologie, novembre 2004, Rapport 1 — *Santé mentale, maladie mentale et toxicomanie : Aperçu des politiques et des programmes au Canada*, chapitre 3, section 3.4.1, p. 65 (citation tirée du témoignage de Jennifer Chambers).

451 H. Chodos, N. Pogue et T. Riordan, 2005, Consultation électronique en matière de services de santé mentale, de maladie mentale et de toxicomanie, phase 1, Service d'information et de recherche parlementaires, Bibliothèque du Parlement.

452 Comité sénatorial permanent des affaires sociales, des sciences de la technologie, novembre 2004, Rapport 1 — *Santé mentale, maladie mentale et toxicomanie : Aperçu des politiques et des programmes au Canada*, chapitre 3, section 3.2.1, p. 47 (citation tirée du témoignage de Rena Scheffer).

guérison alternative. Les cercles de guérison [...] ont leurs racines dans les cérémonies et les traditions, et seuls les sages sont capables de les diriger.

Depuis le début du programme... la majorité des clients ont choisi les cercles de guérison comme méthode de guérison. —Tarry Hewitt[453]

10.2.2 Compenser l'impuissance du rôle patient-usager

Le Comité a appris que le fait de tenir le rôle de patient ou d'usager est démoralisant en soi à cause de l'insistance sur la maladie et l'invalidité[454]. Le fait de dépendre de l'aide de personnes qui revendiquent une expertise exclusive et qui, par définition, sont en position de supériorité mine encore plus l'estime de soi de ceux et celles qu'on définit comme patient ou usager ainsi que leur capacité d'agir efficacement dans leur propre intérêt. Avec le temps, ils peuvent perdre tout espoir et sombrer dans la passivité : l'expérience leur a appris que personne ne s'intéresse à leur point de vue, qu'il y a des gens qui en savent autrement plus qu'eux et qu'il est plus facile (et parfois même plus sûr) de cesser de combattre et de laisser les autres prendre les décisions.

Il est très difficile de faire fi de ce type de commentaire ou de se dire que c'est l'opinion d'une seule personne lorsqu'il s'agit de professionnels de la santé, et il est vraiment difficile de se tenir debout devant l'autorité et de dire : « J'en veux plus », en particulier... lorsqu'on est un malade mental... —Helen Hook[455]

10.2.3 Trouver l'espoir dans un océan de désespoir

Les opinions des personnes ayant une maladie mentale sont souvent réinterprétées comme des manifestations de déni ou comme des « éléments de la maladie », ce qui les prive de tout rôle crédible dans leur propre traitement et dans les décisions touchant leur vie.

Les personnes ayant une maladie mentale se font souvent dire qu'elles ne pourront pas terminer leurs études et ne pourront jamais garder un emploi. Pendant des années, les chercheurs sont parvenus à la conclusion que la maladie mentale implique une chute inexorable aussi bien du point de vue fonctionnel que sur le plan du statut social. Le pronostic était sombre : invalidité permanente, isolement et pauvreté.

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453 16 juin 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/22evc-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

454 S. Mead, D. Hilton et L. Curtis (document non daté), "Peer support: A theoretical perspective", www.mentalhealthpeers.com.

455 15 février 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/05eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

famille) ont discrédité ceux qui cherchaient à s'affirmer et ont contribué encore plus à les réduire au silence.

Les personnes ayant une maladie mentale disent que lorsqu'elles expriment de saines émotions comme la tristesse, la peur ou la colère, on leur répond souvent à coups de médicaments ou de traitements[456]. Les éléments humains de croissance et de plaisir sont transformés en interventions thérapeutiques : bibliothérapie, thérapie par l'art, par la musique, par l'horticulture, thérapie axée sur les relations interpersonnelles ou sur les réseaux sociaux, etc. Ces interventions sont sans doute utiles, mais elles constituent des relations établies par l'intermédiaire de professionnels qui assimilent des activités normales à des traitements.

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> *Ceux qui sont actuellement jugés incapables de travailler ont droit à des prestations mensuelles, à des médicaments subventionnés, s'ils ont de la chance, à un logement subventionné et à l'appui d'un réseau de professionnels de la santé et de programmes gratuits. Bien des gens se sentent pris au piège et n'ont pas la motivation de dresser et d'exécuter un plan leur permettant de mettre fin à ce cercle vicieux de l'impuissance.*
> —*Raymond Cheng*[457]

10.2.4 Une forme d'usurpation de l'identité

On demande aux gens ayant une maladie mentale d'accepter leur diagnostic et d'analyser leur maladie et leur invalidité, au point où ils ont l'impression que leur identité — comme parent, frère ou sœur, employé, étudiant, athlète, artiste ou simplement individu — a été oblitérée ou sérieusement diminuée. Ils sont qualifiés de toxicomanes, de schizophrènes ou de dépressifs. Ils sont en fait *assimilés* à leur maladie[458].

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Certains ont l'impression que leur personnalité a été envahie, conquise et colonisée, un peu de la même façon que les pays sont soumis et occupés par une puissance étrangère.

10.2.5 Recouvrer sa propre histoire

Les personnes ayant une maladie mentale et les membres de leur famille doivent souvent répéter sans fin leur histoire à une succession de professionnels qui ne semblent pas se parler

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456 B. Everett, B., 2000, Consumers and psychiatric survivors confront the power of the mental health system, Waterloo (Ontario), Wilfrid Laurier University Press.

457 17 février 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/07ev-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

458 S. Estroff, 1989, "Self, identity and subjective experiences of schizophrenia: In search of a subject", Schizophrenia Bulletin, vol. 15, nº 2, p. 189-196.

les uns aux autres[459]. Il leur arrive même de perdre le contrôle de ce qu'ils ont vécu. Beaucoup ont l'impression que la réinterprétation de leur expérience dans le langage peu familier de la médecine ou de la réadaptation décrit mal la réalité personnelle de cette expérience. Ces « traductions » peuvent faire abstraction du contexte de leur vie en se concentrant sur leur état plutôt qu'en reconnaissant ce qui va mal dans leur situation[460]. Les expériences de sévices, de racisme, d'oppression, de marginalisation, d'homophobie, de sexisme, de traumatismes de l'enfance, de relations violentes, de perte et de deuil, de pauvreté, d'intimidation, de chômage et d'autres circonstances stressantes de la vie peuvent être omises dans la « traduction » ou, si elles s'y retrouvent, ne pas donner lieu à des interventions en tenant compte. Les facteurs positifs, comme une famille compréhensive, un talent particulier ou le dévouement à la culture et à la collectivité, peuvent aussi être noyés dans une « traduction » trop étroitement axée sur l'évaluation, le diagnostic et les médicaments.

> *Dans l'exercice de mes fonctions, j'entends des histoires de sévices et d'abus, tels qu'elles ont été perçues par les patients. Je ressens alors toute la force de leur colère devant la manière dont ils ont été traités. —Ron Carten*[461]

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The Dream Team (Toronto) (www.thedreamteam.ca). Ce groupe est formé de personnes ayant une maladie mentale et de membres de leur famille qui ont résumé leur expérience personnelle dans des discours de trois minutes prononcés devant des politiciens, des groupes communautaires, des universités et quiconque accepte d'écouter leur message : un logement sûr et abordable sauve des vies. Le groupe organise des présentations payantes. En plus de passer son message central d'une manière intéressante et émouvante, son objectif est de valider l'expérience des sujets et de leur famille.

10.2.6 Répondre aux besoins d'information

Des personnes ayant une maladie mentale et des membres de leur famille ont dit au Comité qu'ils n'ont même pas accès aux renseignements les plus élémentaires.

Des renseignements exacts et complets sur la santé et les services sont essentiels pour jouer le rôle de partenaire à part entière dans son propre traitement ou celui d'un proche. Des personnes ayant une maladie mentale et des membres de leur famille ont dit au Comité qu'ils n'ont même pas accès aux renseignements les plus élémentaires. Par exemple, 33 p. 100 des participants à la consultation en ligne du Comité ont déclaré qu'il est possible d'améliorer les services simplement en offrant plus

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459 Comité sénatorial permanent des affaires sociales, des sciences de la technologie, novembre 2004, Rapport 1 — *Santé mentale, maladie mentale et toxicomanie : Aperçu des politiques et des programmes au Canada*, chapitre 1, section 1.1.1, p. 8 (citation tirée du témoignage de Loïse Forest).

460 S. Mead et C. MacNeil, 2004, "Peer Support: What makes it unique?", www.mentahealthpeers.com.

461 R. Carten, juin 2006, mémoire au Comité sénatorial permanent des affaires sociales, des sciences de la technologie.

d'information[462]. De plus, 66 p. 100 des membres de la famille ont dit que l'information constituait un besoin pressant.

Que signifie un diagnostic de maladie mentale? Quels sont les effets des médicaments? Où puis-je obtenir des services communautaires? Où est-il possible de trouver de l'aide pour un proche toxicomane? Quels sont mes droits?

Les personnes ayant une maladie mentale et les membres de leur famille croient donc que rien ne peut remplacer les conversations avec des pairs et les échanges d'information entre ceux « qui ont déjà connu ça ».

Des professionnels surchargés de travail peuvent soit donner des réponses très laconiques soit communiquer d'une façon difficile à comprendre. Les personnes ayant une maladie mentale et les membres de leur famille croient donc que rien ne peut remplacer les conversations avec des pairs et les échanges d'informations entre ceux « qui ont déjà connu ça ».

> *... si vous avez un problème de santé, adressez-vous à un groupe d'entraide. Vous allez être bien renseigné, car les membres de ces groupes sont des accros de l'information. Ils passent leur temps à naviguer sur le Net en vue de trouver des renseignements sur la façon de se soigner et de guérir. Les groupes d'entraide fournissent un soutien psychologique et des conseils pratiques. Ce sont des motivateurs. Ils disent, « Si je l'ai fait, vous pouvez le faire aussi. » Que peut-on faire d'autre quand on est désespéré? Ce genre d'aide ne se trouve nulle part ailleurs. —Linda Bayers*[463]

Le Comité recommande par conséquent :

46	**Que soient mis en place des programmes permettant de développer des capacités de leadership parmi les personnes ayant une maladie mentale et les membres de leur famille.** **Que le Centre d'échange des connaissances (voir le Chapitre 16) contribue à cette entreprise en facilitant l'accès électronique à l'information et à l'assistance technique à l'intention des personnes ayant une maladie mentale et des membres de leur famille.**

10.2.7 Être entendus

Les gens qui ont l'expérience du système de santé mentale affirment souvent qu'ils sont les derniers à être entendus, au niveau tant individuel que collectif. Défendre les intérêts d'un

462 H. Chodos, N. Pogue et T. Riordan, 2005, Consultation électronique en matière de services de santé mentale, de maladie mentale et de toxicomanie, phase 1, Service d'information et de recherche parlementaires, Bibliothèque du Parlement.

463 10 mai 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/15evc-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

groupe, c'est lui donner une voix. Voilà le but fondamental d'un certain nombre d'organismes d'entraide qui se sont faits les porte-parole des usagers actuels et passés du système de santé mentale et de traitement de la toxicomanie. Avoir notre mot à dire sur les questions qui nous touchent le plus est essentiel à notre bien-être et à notre sens de la citoyenneté. Les groupes intégralement composés des gens qu'ils défendent sont singulièrement habilitants. Ils constituent une ressource vitale pour les collectivités dont on parle souvent, mais à qui on s'adresse rarement.

10.2.8 Trouver la voie de la guérison

Le concept encourageant et optimiste du rétablissement[464] est né du mouvement des usagers qui réagissaient aux expériences négatives connues dans le système officiel de santé mentale et de traitement de la toxicomanie. Se fondant sur une connaissance expérientielle chèrement acquise au cours de leurs propres combats, les personnes ayant une maladie mentale ont lancé un nouveau dialogue qui a commencé à influer sur la politique gouvernementale et qui se manifeste petit à petit dans la littérature professionnelle. Les groupes d'entraide et de soutien par les pairs sont les incubateurs du rétablissement individuel et représentent la clé d'une vaste acceptation du rétablissement, comme principe directeur de tout ce qui se produit dans le système officiel.

Les groupes d'entraide et de soutien par les pairs sont les incubateurs du rétablissement individuel et représentent la clé d'une vaste acceptation du rétablissement, comme principe directeur de tout ce qui se produit dans le système officiel.

10.2.9 Récapitulation

Une identité définie par les professionnels sur la base de la maladie et de l'invalidité peut noyer l'individualité et devenir une étiquette identifiant les personnes ayant une maladie mentale et les membres de leur famille pour les fournisseurs de soins, la société, les médias et ces personnes elles-mêmes. Des forces sociales et systémiques s'allient pour leur présenter un avenir sombre, improductif, solitaire et sans espoir. L'entraide appuie le concept du rétablissement et répond à tous les aspects de l'individualité des gens. La maladie n'est qu'un élément — peut-être le plus petit — d'une vie pleine qui vaut la peine d'être vécue.

10.3 L'ENTRAIDE ET LE SOUTIEN PAR LES PAIRS AU CANADA

L'entraide, c'est des gens qui en aident d'autres, c'est « ceux qui ont connu ça » qui échangent l'expérience commune d'événements ayant transformé leur vie. Le premier avantage de l'entraide, c'est le sentiment d'appartenance, « le grand soulagement qu'on ressent quand on sait qu'on n'est pas seul[465] ». Au Canada, l'entraide et le soutien des pairs ont évolué de trois façons différentes.

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464 Voir chapitre 3, section 2.

465 B. Everett, éd., 1994, "You are not alone: A handbook for facilitators of self help and mutual aid support groups". Disponible par l'entremise de la Mood Disorders Association of Ontario.

10.3.1 Organisations bénévoles

Les organisations d'entraide ne reçoivent généralement pas de financement officiel. Les membres définissent eux-mêmes la façon dont ils s'aident et se soutiennent mutuellement. L'entraide se fonde sur un principe de base : tous les membres sont égaux, ils sont tous des experts de leur propre vie, personne n'en sait plus que les autres et personne ne connaît toutes les solutions[466]. Les expériences individuelles de la vie constituent la « base de connaissances ». L'encouragement et l'espoir sont les « méthodologies » qui ouvrent la voie à l'habilitation et à la guérison.

Le premier avantage de l'entraide, c'est le sentiment d'appartenance, « le grand soulagement qu'on ressent quand on sait qu'on n'est pas seul.

> *Qu'est-ce que le soutien des pairs? Ce sont des groupes de personnes qui ont été en contact avec le réseau de la santé mentale et qui se réunissent régulièrement dans un environnement sûr et confortable pour évoquer leur expérience, pour faire preuve d'empathie et pour prendre le temps de se comprendre. —Raymond Cheng*[467]

Le soutien par les pairs est également une forme d'entraide qui comprend des relations individuelles entre des gens qui ont connu des expériences semblables. Comme l'entraide, c'est un système « qui consiste à donner et à recevoir de l'aide, sur la base des principes fondamentaux du respect, de la responsabilité partagée et d'une entente mutuelle sur ce qui est utile[468] ».

Les pairs ont probablement assisté à des séances d'orientation ou à des programmes de formation pour se doter de renseignements de base sur la façon de se rendre le plus utiles, mais ce sont surtout des bénévoles qui consacrent une part de leur temps à d'autres en espérant faciliter ainsi leur périple.

Les pairs se voient mutuellement comme des personnes ayant une histoire à raconter plutôt que comme des « patients » ou des « cas » à gérer[469]. Ils peuvent être allés plus loin sur la voie de la guérison que ceux qu'ils aident, mais le caractère mutuel de l'expérience est toujours primordial. Ils consacrent du temps aux personnes qui viennent d'apprendre qu'elles ont une maladie mentale, qui viennent de sortir de l'hôpital ou qui sont en pleine crise. Ils offrent des renseignements, des ressources et le réconfort qui vient du récit de leur propre expérience.

Pour se préparer à leur rôle, les pairs ont probablement assisté à des séances d'orientation ou à des programmes de formation pour se doter de renseignements de base sur la façon de se rendre le plus utiles, mais ce sont surtout des bénévoles qui consacrent une part de leur temps à d'autres en espérant faciliter ainsi leur périple.

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466 S. Clay, éd, 2005, *On our own together: peer programs for people with mental illness*, Nashville, TN, Vanderbilt University Press.

467 17 février 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/07ev-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

468 S. Mead, D. Hilton et L. Curtis (document non daté), "Peer support: A theoretical perspective", www.mentalhealthpeers.com.

469 Association canadienne pour la santé mentale, Ontario, Centre de toxicomanie et de santé mentale, Fédération des programmes communautaires de santé mentale et de traitement des toxicomanies de l'Ontario et Initiative ontarienne de développement favorisant l'aide entre pairs, mars 2005, "Consumer/survivor initiatives: Impact, outcomes and effectiveness", www.ofcmhap.on.ca.

Nous insistons pour dire que nous ne sommes pas des professionnels; nous sommes des personnes qui ont perdu un être cher qui s'est suicidé. Par notre propre histoire, nous aidons d'autres personnes à partager leur douleur et à trouver le chemin de la guérison. —George Tomie[470]

10.3.2 Soutien rémunéré des pairs

Certains travailleurs de soutien des pairs sont des paraprofessionnels employés par des fournisseurs de services du système traditionnel de santé mentale et de traitement de la toxicomanie (hôpitaux ou établissements communautaires), dans le cadre d'équipes de traitement communautaire dynamique (TCD) ou de programmes de consultation externes. D'autres travaillent dans des environnements communautaires non médicaux, à titre d'employés engagés sur la base d'une expérience vécue les ayant préparés à faire ce travail plutôt qu'en fonction de connaissances et de titres professionnels.

Les travailleurs de soutien des pairs portent de nombreux titres : défenseur, conseiller ou tuteur des pairs, gestionnaire de cas d'aide, navigateur de système, conseiller des consommateurs ou encore travailleur d'approche des pairs (www.mentalhealthconsumer.net), la variété n'étant limitée que par l'imagination. Contrairement aux bénévoles, ces travailleurs ont reçu une formation pour jouer leur rôle. Beaucoup de programmes de soutien des pairs comprennent des travailleurs comme membres d'équipes volantes de crise et comme membres du personnel de foyers d'hébergement. Ces programmes ont été établis pour réagir à des crises psychiatriques hors du milieu hospitalier[471].

PROFIL

Le Gerstein Centre est un centre de crise non médial ouvert 24 heures sur 24 dans le centre-ville de Toronto. Il engage des gens sur la base d'expériences vécues pour former des équipes volantes de crise et donner des soins de courte durée dans des foyers d'hébergement et des consultations téléphoniques d'urgence. Sa philosophie: environnement et soutien individualisés, adaptés aux besoins et aux vœux des utilisateurs, respectueux de leur autonomie, de leur dignité et de leurs capacités. Le plus ancien des programmes canadiens de ce type, le Gerstein Centre célèbre cette année son 15e anniversaire.

10.3.3 Emploi de travailleurs rémunérés de soutien des pairs dans des organisations autonomes d'aide aux usagers et aux familles

En 1991, le gouvernement de l'Ontario a lancé l'Initiative d'élaboration de programmes pour les consommateurs et les survivants et l'a dotée d'un budget initial de 3,1 millions de dollars (aujourd'hui 4,5 millions). Ce programme est depuis devenu l'Initiative ontarienne de développement favorisant l'aide entre pairs, dont le principe de base est le soutien des pairs.

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470 9 mai 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/15evb-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

471 S. Mead et D. Hilton, 2003, "Crisis and connection", *Psychiatric Rehabilitation Journal*, vol. 27, nº 1, p. 87-94.

Les organisations financées ne devaient pas dispenser de services tels que les conseils ou la gestion de cas, comme les organisations professionnelles, mais s'appuyer plutôt sur la culture de mutualité et les connaissances expérientielles qui constituent la base de l'entraide. Les initiatives usagers-survivants qui en ont résulté emploient des pairs dans des rôles qui comprennent le développement économique ou communautaire, le soutien individuel entre pairs, les activités sociales, l'éducation des pairs, la défense des intérêts et les communications sur Internet.

PROFIL

L'Initiative ontarienne de développement favorisant l'aide entre pairs (www.opdi.org) ou OPDI a succédé à l'Initiative de développement des consommateurs-survivants en réponse au besoin d'assistance technique exprimé par les initiatives consommateurs-survivants. L'organisation offre de l'aide pour la constitution de conseils d'administration, le développement organisationnel, le règlement des différends ainsi que pour l'accroissement du nombre de membres et le développement des ressources.

10.3.4 Récapitulation

Le Comité reconnaît la valeur des organisations d'entraide et de soutien des pairs. Il est conscient des difficultés financières auxquelles beaucoup d'entre elles sont confrontées, partout dans le pays.

Au Canada, comme ailleurs, les programmes d'entraide et de soutien des pairs se sont développés d'une façon ponctuelle, selon les besoins. Bien que certains aient été financés par les gouvernements, la plupart sont autonomes, fonctionnant avec des budgets très limités et se débattant pour survivre. Mais ces programmes survivent malgré tout, grâce à la passion, à l'engagement et au dévouement de leurs membres. Le soutien rémunéré des pairs a fait son apparition dans des secteurs isolés, avec l'appui financier des provinces et des territoires. À titre de complément nouveau et fragile du système de santé mentale et de traitement de la toxicomanie, les programmes d'entraide et de soutien des pairs ont un avenir assez incertain.

> *Nous pensons que le groupe de fournisseurs de services le plus important, ce sont les familles, et que les groupes d'entraide constituent un soutien important pour les personnes qui souffrent d'une maladie mentale. Au Manitoba, l'efficacité des groupes d'entraide est éprouvée. Ce sont des alliés des professionnels en santé mentale pour les malades et leur famille.*
>
> *Les groupes d'entraide doivent continuer de faire partie du système et de consacrer du temps à aider leurs membres, plutôt que d'investir temps et ressources pour la collecte de fonds. On devrait leur confier la responsabilité de dispenser les services. On doit protéger leurs approches individuelles. —Annette Osted*[472]

472 31 mai 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/16eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

Le Comité reconnaît la valeur des organisations d'entraide et de soutien des pairs. Il est conscient des difficultés financières auxquelles beaucoup d'entre elles sont confrontées, partout dans le pays. Le Comité recommande par conséquent :

47	**Qu'un financement soit établi par le truchement du Fonds de transition en santé mentale (voir le Chapitre 16) avec pour objectif précis :** • **d'accroître le nombre de travailleurs rémunérés de soutien des pairs dans les organisations communautaires de santé mentale;** • **de fournir un financement stable pour renforcer les initiatives existantes de développement favorisant l'entraide, en lancer des nouvelles (y compris les groupes familiaux) et bâtir un réseau d'initiatives d'entraide et de soutien des pairs couvrant tout le pays.** **Que le gouvernement fédéral donne l'exemple, en développant les programmes innovateurs tels que le Programme national de soutien par les pairs à l'intention des membres actuels des Forces canadiennes et des anciens militaires, et appuie grâce à des niveaux de financement suffisants des programmes d'entraide et de soutien des pairs destinés à la clientèle relevant de la compétence fédérale.**

10.4 RECHERCHE SUR L'ENTRAIDE ET LE SOUTIEN DES PAIRS

D'après les témoignages des personnes ayant une maladie mentale et des membres de leur famille, l'entraide et le soutien des pairs sont efficaces et peuvent, dans de nombreux cas, sauver des vies.

> *Je n'éprouve aucune honte. Je dois ma vie au SSVSO (Projet de soutien social aux victimes de stress opérationnel). —Caporal Clemett*[473]

Des études évaluant l'efficacité de l'entraide et du soutien des pairs commencent à paraître. La documentation qui existe en ce moment tend à être descriptive ou présente les résultats de sondages sur la satisfaction des membres[474]. Toutefois, aux États-Unis, de nouvelles recherches documentent les résultats des programmes de soutien par les pairs[475] tandis qu'au Canada, quelques études récentes se distinguent par leur rigueur scientifique.

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473 La Feuille d'érable, février 2005, bulletin des Forces canadiennes.

474 Par exemple, D. Corring, 2002, "Quality of life: Perspectives of people with mental illness and family members", *Psychiatric Rehabilitation Journal*, vol. 25.

475 J. Campbell et J. Leaver, 2003, "Report from NTAC's National Experts meeting on emerging new practices in organized peer support". Disponible par l'entremise du U.S. Department of Health and Human Services.

Nelson et ses collaborateurs ont examiné quatre initiatives ontariennes de soutien des usagers qui ont permis d'organiser des rencontres de formation, des occasions de défense d'intérêts et des réseaux sociaux, parallèlement au soutien par les pairs[476]. Lorsque des membres s'inscrivaient à ces groupes de soutien, près de 40 p. 100 d'entre eux n'avaient pas un logement stable, un tiers avaient dû être hospitalisés dans les neuf mois précédents et 25 p. 100 ressentaient la détresse des symptômes psychiatriques. Après 18 mois, le nombre d'hospitalisations et de visites dans les salles d'urgence avait baissé par rapport à un groupe témoin de non-membres. Les membres étaient plus nombreux à avoir un logement stable, manifestaient moins de symptômes et ont signalé qu'ils avaient noué davantage de liens d'amitié, ce qui avait entraîné une amélioration générale de leur qualité de vie. Les données qualitatives montraient que les membres appréciaient le soutien des pairs et se réjouissaient d'avoir un endroit sûr pour se rétablir et s'épanouir à l'abri des jugements négatifs de la société et de l'indifférence de leur collectivité.

Forchuk a étudié les économies attribuables au soutien par les pairs[477]. En utilisant un plan d'enquête aléatoire, elle a examiné les expériences de 390 patients de 26 hôpitaux du sud-ouest de l'Ontario. Elle a constaté que le soutien par les pairs, allié au suivi en établissement jusqu'à ce que le malade sortant soit mis en contact avec des services communautaires, avait permis d'économiser dans une année 12 millions de dollars en frais d'hospitalisation. « Le traitement d'une seule personne suffirait pour payer un coordonnateur bénévole à temps partiel grâce à la réduction des coûts d'hospitalisation et de salle des urgences. »

Une étude des initiatives usagers-survivants, également en Ontario, a révélé qu'avec le soutien des pairs, les membres recouraient moins souvent aux services de santé mentale (les jours d'hospitalisation ayant baissé de 38,36 à 4,29 et les contacts en cas de crise, de 3,54 à 0,81). Les membres avaient également réussi à renforcer leurs appuis sociaux et communautaires[478].

Compte tenu de ces conclusions, le Comité recommande :

48	**Que des recherches soient entreprises pour :** • **quantifier les avantages de l'entraide et du soutien par les pairs pour les participants;** • **déterminer les économies que le système des soins de santé peut réaliser grâce à des initiatives de soutien par les pairs.** **Qu'une partie de ces économies soit affectée au financement d'initiatives d'entraide et de soutien par les pairs.**

476 G. Nelson, 2004, "What was learned about members of CSIs", dans *Making a Difference*. Disponible par l'entremise du Centre de toxicomanie et de santé mentale.

477 C. Forchuk, 2002, "Therapeutic relationships: From hospital to community". Disponible par l'entreprise de la Fondation canadienne de la recherche sur les services de santé, www.chrsf.ca.

478 J. Trainor et coll., 1997, "Beyond the service paradigm: The impact of consumer/survivor initiatives", *Psychiatric Rehabilitation Journal*, vol. 21, p. 132-140.

À part la recherche sur les résultats, d'importants efforts ont été déployés au Canada pour déterminer de quelle façon les connaissances des usagers et de leur famille peuvent influer sur les décisions relatives au traitement clinique, au service communautaire et aux politiques gouvernementales. Dans un important remaniement du document du cadre de soutien de l'Association canadienne pour la santé mentale[479], les auteurs évoquent une idée, qu'ils appellent la base de ressources du savoir, qu'ils estiment essentielle à l'avancement de la compréhension de la santé mentale, des maladies mentales et des toxicomanies. À part les sources traditionnelles de connaissances, comprenant les preuves tirées des sciences sociales (comme les études de résultats mentionnés ci-dessus) et les connaissances médicales et cliniques (études sur les fonctions cérébrales, par exemple), la base de ressources du savoir comprendrait en outre des connaissances expérientielles (la compréhension vécue au jour le jour de la maladie qu'offrent les personnes ayant une maladie mentale et les membres de leur famille) ainsi que la sagesse découlant des coutumes, de la tradition et de l'histoire (valorisation de la diversité et autres moyens de guérison).

> *Je crois qu'il faut encourager le soutien par les pairs et le financer à l'intention des personnes qui ont une connaissance personnelle de la maladie mentale. Seules des personnes qui ont connu la maladie mentale peuvent vraiment comprendre à quoi ressemble la vie d'une personne atteinte. C'est pour cette raison que nous avons une capacité remarquable de nous aider les uns les autres, que les professionnels ne peuvent tout simplement pas égaler.*
>
> *Les familles ont également besoin de soutien par les pairs pour être en mesure de s'entraider, de contribuer à l'orientation du système et de défendre les intérêts de leurs proches.*
>
> *Nous pourrions mieux nous aider les uns les autres si nous disposions de ressources financières parce que beaucoup de gens vivent aussi dans la pauvreté ou ont un revenu très limité. Les transports, les communications par téléphone ou par Internet sont souvent hors de leur portée.*
> *—Anonyme*

10.4.1 Récapitulation

La recherche axée sur l'entraide et le soutien par les pairs est relativement récente, mais les conclusions sont prometteuses. Les théories sur lesquelles se fondent les quelques études déjà réalisées et les méthodologies employées sont en train d'étendre l'horizon de la recherche d'une manière aussi nouvelle qu'innovatrice.

La recherche axée sur l'entraide et le soutien par les pairs est relativement récente, mais les conclusions sont prometteuses.

Fait important, les personnes ayant une maladie mentale et les membres de leur famille participent à la formulation des questions, de même qu'à la collecte et à l'analyse des données

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479 J. Trainor, E. Pomeroy et B. Pape, 2004, *A framework for support. Third edition*, Toronto, Association canadienne pour la santé mentale, bureau national.

et à la diffusion des résultats. De telles pratiques de transfert des connaissances permettent à la santé mentale et au traitement de la toxicomanie de prendre une orientation nouvelle et prometteuse.

Le travail conceptuel, dont témoigne par exemple la nouvelle édition du cadre de soutien, ouvre la voie à de grandes perspectives comprenant la participation des usagers et de leur famille et valorisant leur rôle dans l'obtention de nouvelles connaissances.

Le Comité recommande par conséquent :

49	**Que les Instituts de recherche en santé du Canada (IRSC) appuient la recherche sur l'entraide et le soutien par les pairs et, pour retenir les projets de recherche à financer, adoptent un processus d'examen qui favorise et encourage les méthodologies fondées sur la participation que les personnes ayant une maladie mentale et les membres de leur famille préfèrent et trouvent efficaces.**

10.5 NOUVELLES VOIX

L'entraide et le soutien par les pairs, même s'ils constituent un complément opportun à l'ensemble des traitements et des services communautaires existants, représentent de bien des façons un défi pour la pensée traditionnelle. Les personnes ayant une maladie mentale ont leur propre point de vue sur les causes et le traitement de la maladie mentale et des toxicomanies. Les familles parlent du manque d'accès aux services, de leur exclusion du traitement de leur proche et du refus par les gouvernements de faire adopter des lois permettant d'imposer des traitements[480].

10.5.1 Prestation des services

Parmi les participants à la consultation en ligne du Comité, 41 p. 100 ont dit avoir eu des expériences négatives avec les fournisseurs de services[481] : 33 p. 100 ont fait état du manque de respect comme étant leur pire expérience, tandis que d'autres ont parlé de mauvais diagnostics et de mauvais traitements (22 p. 100), de retards dans le traitement (20 p. 100), de violence physique (16 p. 100), de privation de traitement (14 p. 100) et d'hospitalisation forcée (10 p. 100). Au cours de la deuxième phase de la consultation, les personnes ayant une maladie mentale et les membres de leurs familles ont également fait la distinction entre la

480 Voir également le chapitre 4, section 4.3.3, pour un examen connexe du pouvoir des commissions de révision d'ordonner des traitements.

481 H. Chodos, N. Pogue et T. Riordan, 2005, Consultation électronique en matière de services de santé mentale, de maladie mentale et de toxicomanie, phase 1, Service d'information et de recherche parlementaires, Bibliothèque du Parlement.

disponibilité des services (difficiles à trouver) et leur accessibilité (les services existent, mais il y a trop d'obstacles à surmonter pour y avoir accès)[482].

Si elles admettent l'importance de l'apport des professionnels, les personnes atteintes d'une maladie mentale ont néanmoins souvent l'impression que ceux-ci ne sont pas vraiment à l'écoute et ne les traitent pas de manière globale; leur vie devient alors une série de problèmes ponctuels pris en charge de manière étroite en fonction seulement des impératifs des diverses spécialités professionnelles. Elles ont aussi souvent le sentiment d'être des « objets » que l'on « gère » et non des êtres humains ayant une véritable relation avec les professionnels de la santé auxquels elles s'adressent.

Parmi les participants à la consultation en ligne du Comité, 41 p. 100 ont dit avoir eu des expériences négatives avec les fournisseurs de services.

La sécurité assurée par les groupes d'entraide a permis aux gens de s'exprimer librement et de publier leur point de vue. Leurs expériences personnelles donnent plus de force à leurs récits. De ce fait, les professionnels, les décideurs, les administrateurs et le public sont mis au défi de modifier leur opinion traditionnelle sur les personnes ayant une maladie mentale ou une toxicomanie et sur la façon dont les services conçus pour répondre à leurs besoins sont structurés et dispensés.

> *Je me souviens de ma propre expérience quand j'ai voulu ouvrir un centre d'entraide et, j'ajouterai, le faire en français. J'ai fait face à beaucoup d'opposition parce qu'on a déclaré : « Il n'y aura pas de professionnels autour. Pouvez-vous réellement faire cela seul? »*
>
> *Nous avons fait la sourde oreille, nous nous sommes entêtés, nous n'avons pas écouté les sceptiques et 18 ans plus tard, me voici, c'est un concept qui a été accepté. Donc, à cet égard, la situation s'est améliorée car on a enfin reconnu que les clients de services de santé mentale peuvent faire les choses eux-mêmes, pour eux-mêmes et prendre leurs propres initiatives. —Eugene LeBlanc*[483]

10.5.2 Rétablissement

Au lieu d'évoquer les diagnostics, les symptômes, les schémas de financement, le recours aux services et le fardeau économique, les personnes ayant une maladie mentale préfèrent parler d'espoir, de rétablissement, de contacts, de récits, de voyage vers la guérison, d'attention affectionnée, de dignité, d'amis, de spiritualité, d'habilitation et de pouvoir transformateur des crises[484]. Ce sont là des idées complexes qui se prêtent difficilement à la mesure et à la gestion, qui s'inscrivent mal dans un système axé sur les procédures normalisées, les mesures comptables uniformes et les pratiques exemplaires homogènes fondées sur des faits.

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482 Ascentum, juin 2005, Rapport final sur la consultation électronique du Comité sénatorial permanent des Affaire sociales, des sciences et de la technologie.

483 11 mai 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/15eve-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

484 S. Mead, 2003, "Defining peer support", www.mentahealthpeers.com.

Les familles, tout en s'accommodant mieux de la psychiatrie et des médicaments que ceux qui subissent les traitements, préconisent aussi la prestation de services extérieurs au cercle médical de soins, comme un logement abordable, le soutien du revenu et le travail.

> *L'accent est mis sur le bien-être et non pas sur la maladie, sur les aptitudes et non les incapacités, sur l'acceptation de ses limites plutôt que de vivre diminué à l'intérieur du carcan de ses limites, de se concentrer sur le début du processus de rétablissement au lieu de rester stagnant, prisonnier de sa détresse. —Joan Edwards-Karmazyn*[485]

Malgré l'importance croissante de leur rôle, les personnes ayant une maladie mentale et les membres de leur famille n'ont pas en général l'impression d'être entendus. Il y a d'ailleurs des raisons de croire qu'ils ne le sont pas[486]. Même s'il est vrai que le rétablissement, comme concept déterminant, a commencé à apparaître dans la littérature de la santé mentale (il est beaucoup plus courant dans le domaine des toxicomanies), son potentiel révolutionnaire est mal compris et n'a pas généralement été pris en compte.

Au lieu d'évoquer les diagnostics, les symptômes, les schémas de financement, le recours aux services et le fardeau économique, les personnes ayant une maladie mentale préfèrent parler d'espoir, de rétablissement, de contacts, de récits, de voyage vers la guérison, d'attention affectionnée, de dignité, d'amis, de spiritualité, d'habilitation et de pouvoir transformateur des crises.

Les familles, tout en s'accommodant mieux de la psychiatrie et des médicaments que ceux qui subissent les traitements, préconisent aussi la prestation de services extérieurs au cercle médical de soins.

10.5.3 Récapitulation

Les nouvelles opinions ne sont souvent pas prises au sérieux parce que ceux qui les avancent peuvent exprimer des points de vue quelque peu divergents. Ils peuvent ne pas s'entendre entre eux, et le langage qu'ils utilisent peut ne pas refléter les courants dominants. Toutefois, en ce qui concerne les personnes ayant une maladie mentale ou une toxicomanie et les membres de leur famille, ces voix disparates offrent la perspective d'un dialogue plus riche et plus nuancé entre l'ensemble des intervenants, de même qu'elles évoquent la possibilité de mesures améliorées de responsabilisation.

Les « usagers » du système canadien de santé mentale et de traitement de la toxicomanie disent qu'ils ne peuvent pas trouver de services quand ils en ont besoin et que lorsqu'ils ont la chance d'obtenir de l'aide, ils sont souvent insatisfaits des services qui leur sont dispensés.

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485 14 juin 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/22eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

486 Association canadienne pour la santé mentale, Ontario, Centre de toxicomanie et de santé mentale, Fédération des programmes communautaires de santé mentale et de traitement des toxicomanies de l'Ontario et Initiative ontarienne de développement favorisant l'aide entre pairs, mars 2005, "Consumer/survivor initiatives: Impact, outcomes and effectiveness", www.ofcmhap.on.ca.

Les « usagers » du système canadien de santé mentale et de traitement de la toxicomanie disent qu'ils ne peuvent pas trouver de services quand ils en ont besoin et que lorsqu'ils ont la chance d'obtenir de l'aide, ils sont souvent insatisfaits des services qui leur sont dispensés. Ces critiques ne sont ni vagues ni infondées. Elles montrent d'une façon précise ce qui ne va pas. Cette précieuse information doit servir à améliorer le ciblage des investissements futurs du gouvernement et de la surveillance des résultats. Le Comité recommande par conséquent :

Cette précieuse information doit servir à améliorer le ciblage des investissements futurs du gouvernement et de la surveillance des résultats.

50	**Que les mesures de responsabilisation relatives aux services de santé mentale et de traitement de la toxicomanie portent non seulement sur des questions de processus, comme le nombre de visites, les heures de consultation ou les sommes dépensées, mais aussi sur les résultats, comme le respect, la préservation de la dignité et l'insistance sur l'espoir et le rétablissement, car ce sont des aspects qui figurent parmi les principales préoccupations des personnes ayant une maladie mentale et les membres de leur famille.**

10.6 CONTRADICTIONS ET DÉFIS

À mesure que les services d'entraide et de soutien par les pairs se développent et deviennent aptes à solliciter du financement des gouvernements et d'autres sources, ils auront à affronter le défi de rester fidèles à leurs objectifs tout en se conformant aux exigences complexes, aux conditions et aux contraintes administratives qui accompagnent l'argent.

10.6.1 Travail rémunéré et bénévolat

Les groupes d'entraide et de soutien par les pairs se fondent sur l'indépendance, comme valeur fondamentale. Cela signifie que l'une des grandes raisons pour lesquelles leurs membres connaissent le succès et la satisfaction est qu'ils sont libres de fournir l'aide par leurs propres moyens, sans directives extérieures provenant de bailleurs de fond ou d'autres intervenants. Toutefois, le fait d'avoir un travail à faire est important et valorisant. Par conséquent, la possibilité d'une carrière rémunérée comme travailleur de soutien des pairs ou comme membre du personnel d'un programme financé d'entraide ou de soutien par les pairs peut constituer un objectif valable, vraiment digne d'être poursuivi.

La possibilité d'une carrière rémunérée comme travailleur de soutien des pairs ou comme membre du personnel d'un programme financé d'entraide ou de soutien par les pairs peut constituer un objectif valable, vraiment digne d'être poursuivi.

> *Je veux cependant être claire : il ne faut pas que ces postes [de soutien par les pairs] restent symboliques. Ces postes méritent d'être rémunérés,*

et le salaire doit permettre de vivre; pas de survivre, de vivre [soulignement ajouté]. —Becky McFarlane[487]

La reconnaissance de l'entraide et du soutien par les pairs comme profession rémunérée ouvrira la porte à toutes sortes de possibilités susceptibles d'être très avantageuses : établissement de titres de compétences accessibles grâce à des études officielles, création de spécialités secondaires, formation d'associations et réglementation au moyen de codes d'éthique et de conseils de discipline. On courrait alors le risque de voir ces « structures » traditionnelles transformer l'entraide et le soutien par les pairs en quelque chose de différent, qui les priverait du motif fondamental de leur efficacité : la participation de leurs membres exclusivement en fonction de leurs expériences vécues.

La reconnaissance de l'entraide et du soutien par les pairs comme profession rémunérée ouvrira la porte à toutes sortes de possibilités susceptibles d'être très avantageuses

10.6.2 Services financés (liés) et non financés (libres mais sans ressources)

Les exigences de responsabilisation qui accompagnent le financement par le gouvernement et par de nombreux autres organismes sont onéreuses. Le simple fait de remplir les demandes nécessite beaucoup de temps et de connaissances spécialisées. Les organismes traditionnels ont souvent des employés exclusivement chargés d'établir les rapports qu'exigent leurs bailleurs de fonds. Le fardeau de la collecte de données s'alourdit constamment, les responsables des programmes conventionnels ayant l'obligation de tenir des dossiers détaillés aussi bien sur support électronique que sur papier pour décrire les services offerts en fonction des dépenses, tout en se conformant aux mesures de sécurité et aux lois sur la protection des renseignements personnels. Compte tenu de leur nature, les groupes d'entraide et de soutien par les pairs ne demandent pas de renseignements médicaux privés, certains d'entre eux ne tenant même pas à connaître le nom et l'adresse des participants. Leur tradition est essentiellement orale et leur activité la plus appréciée, qui consiste à raconter des histoires, défie toute conversion en éléments de données.

Le manque de financement contribue souvent à la marginalisation des groupes d'entraide et de soutien par les pairs, dont la voix, qu'ils soient financés ou non, est alors noyée sous la marée des intérêts professionnels.

Beaucoup de groupes bien connus d'entraide et de soutien par les pairs offrent des services efficaces sans financement externe (AA étant l'exemple le plus connu). Il y a cependant de nombreux exemples d'organisations d'entraide qui sollicitent des fonds, reçoivent des subventions gouvernementales et cherchent à obtenir des dons de sources privées.

Toutefois, la plupart s'accommodent en permanence d'un budget très minime et n'ont pas les moyens de lancer les initiatives dont leurs membres ont besoin ou d'être présentes lors des importantes rencontres de décision. Beaucoup de ces organisations ont de la difficulté à obtenir des fonds parce qu'elles contestent le système même par lequel passe l'argent. Certaines décident de ne pas solliciter d'argent du gouvernement, craignant d'être soumises à des contraintes pouvant changer leur façon de procéder. Quelles que soient les raisons, le

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487 15 février 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/05evb-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

manque de financement contribue souvent à la marginalisation des groupes d'entraide et de soutien par les pairs, dont la voix, qu'ils soient financés ou non, est alors noyée sous la marée des intérêts professionnels.

> *Toutes ces initiatives ont une chose en commun : elles sont sous-estimées, mal financées et, parce qu'elles ne s'inscrivent pas dans le cadre culturel prévalant des services cliniques et syndiqués, elles ne sont pas prioritaires pour les gouvernements qui les considèrent souvent comme un rajout de dernière minute. À bien des égards, le système de santé mentale est constitué de mesures purement symboliques. —Eugene LeBlanc*[488]

10.6.3 Les limites de la recherche sur les pratiques exemplaires

Les concepts tels que les pratiques exemplaires n'ont pas bien servi les groupes d'entraide et de soutien par les pairs. L'approche des modèles — de programmes, de pratiques, de logique ou d'évaluation — qui est courante parmi les professionnels se prête mal au caractère informel de la culture d'entraide. À cause de ce facteur, peu d'études ont été réalisées sur les avantages de l'entraide et du soutien par les pairs. Par ailleurs, comme la recherche traditionnelle a eu tendance à faire abstraction du point de vue des gens ayant une expérience directe de la maladie mentale, elle s'est coupée d'une source d'information nécessaire à l'évaluation des résultats des interventions en santé mentale.

Comme beaucoup de groupes marginalisés, les personnes ayant une maladie mentale et les membres de leur famille ont de bonnes raisons de se méfier de la plupart des méthodes traditionnelles de recherche et de préférer les méthodes non traditionnelles, comme la recherche participative, ou sous-utilisées, comme les méthodes qualitatives. Toutefois, avec l'augmentation du financement gouvernemental, certains groupes tentent de définir des pratiques exemplaires, dans l'espoir qu'en adoptant les méthodes de la culture professionnelle, ils gagneront le respect des autres et auront de meilleures chances d'obtenir du financement.

> *L'efficacité de l'effort autonome et des groupes de soutien dans le rétablissement a été très bien documentée... Le soutien financier pour la promotion et le financement de ces initiatives importantes est urgent. Le mouvement d'entraide prend de l'ampleur, mais il pourrait le faire beaucoup plus rapidement. —Susan Kilbridge-Roper*[489]

10.6.4 Récapitulation

Il n'y a pas de doute que des tensions existent entre le caractère informel de l'entraide et du soutien par les pairs et le caractère formel des méthodes de recherche et de la littérature des professionnels de la santé. Compte tenu de questions telles que les suivantes :

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488 11 mai 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/15eve-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

489 9 mai 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/15eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

- Les programmes de soutien dirigés par les pairs peuvent-ils et devraient-ils être classés, évalués et compris en fonction des mêmes critères que les services dispensés par le système traditionnel de santé mentale?

- La normalisation des services doit-elle prendre le pas sur le lien curatif caractérisant les relations entre pairs, les transformant en unités de temps facturables[490]?

Il est très probable que les programmes de soutien par les pairs ne pourront pas atteindre leur plein potentiel s'ils ne sont pas couverts par des mécanismes d'agrément et de responsabilisation. Par conséquent, le Comité recommande :

51	**Que les exigences en matière de responsabilisation établies pour les groupes d'entraide et de soutien par les pairs ne soient pas exagérément contraignantes et que l'on fasse en sorte que ces groupes puissent y répondre.** **Que des procédures d'agrément et d'accréditation des initiatives d'entraide et de soutien par les pairs, dirigées par les usagers et les familles, soient élaborées et financées pour assurer la qualité et appuyer la contribution unique de ces initiatives.**

10.7 MAINTENIR ET PROTÉGER

Les groupes d'entraide et de soutien par les pairs (de même que la recherche les visant particulièrement) affirment que les solutions qu'ils offrent aux personnes ayant une maladie mentale ou une toxicomanie et aux membres de leur famille sont plus efficaces et économiques que les services professionnels.

Tandis que les organisations traditionnelles affirment qu'un manque de fonds les empêche d'être efficaces, les groupes marginalisés entendent souvent dire le contraire : un financement extérieur risque de les détourner de leur mission. Les personnes ayant une maladie mentale et les membres de leur famille ont durement combattu sur la scène de la maladie mentale et de la toxicomanie, avançant difficilement d'un pas à la fois et contribuant ainsi très sensiblement à la façon dont nous envisageons la maladie mentale et la toxicomanie. L'idéal du rétablissement est attribuable à leur action, de même que la réorientation du traitement, du soutien et des services vers le but du rétablissement.

> *Comment pouvons-nous conjuguer jour et nuit avec une maladie mentale? N'est-il pas normal de parler à des personnes qui vivent la même situation? Je trouve que ça l'est. —Linda Bayers*[491]

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490 J. Campbell et J. Leaver, 2003, "Report from NTAC's National Experts meeting on emerging new practices in organized peer support". Disponible par l'entremise du U.S. Department of Health and Human Services.

Il y a certes des contradictions et des désaccords entre les personnes et les familles touchées par la maladie mentale et la toxicomanie, mais cela n'a rien d'extraordinaire. Il est également vrai que les capacités et les attributs nécessaires pour surmonter une maladie mentale ou une toxicomanie — ou, dans le cas d'un membre de la famille, pour s'aider soi-même, soutenir un proche et naviguer dans le système — ne sont pas les mêmes que celles qu'il faut pour diriger une organisation complexe sans but lucratif. Quoi qu'il en soit, l'éducation des professionnels de la santé ne comprend pas grand-chose en matière d'administration ou de gestion. Ordinairement, du moins dans les professions de la santé, ces compétences s'acquièrent sur le tas.

Le Comité croit que l'avantage qu'il y a à investir dans l'entraide et le soutien par les pairs pèse plus lourd que le risque d'une altération de cette culture par suite d'effets négatifs imprévisibles. L'essentiel est d'assurer l'équilibre entre l'appui financier, l'indépendance et la capacité de se conformer aux exigences nécessaires de responsabilisation.

Pendant des décennies, les organisations professionnelles ont obtenu un financement assez considérable. Elles ont bâti une infrastructure (ordinateurs, logiciels et employés spécialisés en finances et en informatique) pour satisfaire aux exigences de responsabilisation. Les organisations d'entraide et de soutien par les pairs créées par les usagers et les membres de leur famille doivent commencer pratiquement à zéro, n'ayant reçu par le passé que peu ou pas de fonds extérieurs.

Les groupes d'entraide et de soutien par les pairs (de même que la recherche les visant particulièrement) affirment que les solutions qu'ils offrent aux personnes ayant une maladie mentale ou une toxicomanie et aux membres de leur famille sont plus efficaces et économiques que les services professionnels. Cette assertion est difficile à contester, étant donné que ces groupes offrent une aide gratuite ou d'un coût très minime. Il est à craindre, si ces groupes sont dispensés de l'obligation de se conformer à des procédures normalisées de responsabilisation à cause de leur manque d'infrastructure, qu'ils ne s'embourbent encore plus profondément dans un rôle de parents pauvres qui les maintiendrait à l'écart des cercles du pouvoir réel où se prennent les décisions importantes.

Pour ceux qui pensent que ces appréhensions sont futiles, nous ferons remarquer que la stratégie australienne de santé mentale, louée dans les milieux internationaux pour son insistance sur la participation des usagers et de leur famille et sur ses valeurs d'espoir et de rétablissement, a été confrontée à de graves difficultés lors de sa mise en œuvre. Par exemple, malgré l'excellence de son travail de renforcement des capacités, le National Resource Centre for Consumer Participation s'est vu retirer son financement en septembre 2004 et n'existe plus.

Le Comité croit que l'avantage qu'il y a à investir dans l'entraide et le soutien par les pairs pèse plus lourd que le risque d'une altération de cette culture par suite d'effets négatifs imprévisibles. L'essentiel est d'assurer l'équilibre entre l'appui financier, l'indépendance et la capacité de se conformer aux exigences nécessaires de responsabilisation.

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491 10 mai 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/15evc-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

L'essor du mouvement d'entraide dans le domaine de la santé mentale et de la toxicomanie annonce un important changement dans les rapports de force traditionnels de notre système de soins. Avec un financement suffisant et régulier, allié à un engagement gouvernemental permanent, il sera possible d'en concrétiser tous les avantages.

> *Je crois que les initiatives d'entraide comme les projets usagers-survivants et beaucoup d'autres ressources d'entraide pour la santé mentale et la toxicomanie doivent être officiellement reconnues, à titre de solutions très efficaces et moins menaçantes que d'autres menant vers le rétablissement. Ces initiatives ont donc besoin d'un financement suffisant — et non honteusement insuffisant — pour l'excellent travail qu'elles permettent d'accomplir. —Anonyme.*

Le Comité recommande par conséquent :

52	**Que les organisations existantes et nouvelles pour les usagers et leur famille soient financées à un niveau annuel durable.** **Que de vastes coalitions d'organisations d'entraide et de soutien par les pairs soient constituées et financées pour que les organisations cessent d'être isolées et puissent former des réseaux les unes avec les autres.**

10.8 CONCLUSION

Les différentes perspectives des personnes ayant une maladie mentale et les membres de leur famille sont très précieuces. Il importe d'appuyer leurs organisations grâce à un financement annuel stable et suffisant et de les inclure dans l'éducation publique et les activités de recherche et de transfert de connaissances, de façon à soutenir la croissance et le développement des structures et des capacités qui permettront à toutes les organisations qui dispensent des services aux personnes et aux familles touchées par la maladie mentale et la toxicomanie de fonctionner efficacement.

PARTIE IV

Recherche et technologie de l'information

CHAPITRE 11:
LA RECHERCHE, L'ÉTHIQUE ET LA VIE PRIVÉE

11.1 INTRODUCTION

> *Une bonne information est une condition préalable à de bonnes décisions.... C'est particulièrement vrai dans le cas des troubles mentaux qui, jusqu'à tout récemment, ont été nettement négligés en tant que questions de santé publique. — Organisation mondiale de la santé*[492]

La recherche est cruciale pour développer l'information de qualité nécessaire pour la planification et la prestation efficaces du spectrum complet des services de santé mentale. La recherche est nécessaire :

- pour accroître la reconnaissance et la compréhension de la maladie mentale,
- pour démontrer de quelle façon on peut effectuer au mieux la prévention de la maladie mentale,
- pour fournir l'assise de stratégies d'intervention précoce dans le domaine de la maladie mentale afin de réduire la gravité de la maladie et d'aboutir à un rétablissement plus rapide,
- pour élaborer des traitements plus efficaces; et
- pour donner lieu à des interventions meilleures et plus rentables grâce au recours à la technologie.

Des progrès considérables ont été marqués dans tous ces domaines au cours des dernières années. La recherche menée au Canada a largement contribué, à l'échelle tant nationale qu'internationale non seulement à approfondir les connaissances sur le fonctionnement du cerveau mais aussi à mettre au point de nouveaux médicaments et de meilleures stratégies de traitement des troubles mentaux. Les personnes atteintes de maladie mentale peuvent dorénavant choisir dans un éventail beaucoup plus large d'options de traitement.

En conséquence, il est extrêmement important que le Canada consacre les ressources nécessaires à une recherche efficace, diffuse les résultats de la recherche, traduise ces résultats dans la pratique clinique, élabore un programme national de recherche et recueille les données nécessaires pour suivre la santé mentale au Canada. Les personnes ayant une maladie mentale sont particulièrement vulnérables et devraient être traitées avec un soin particulier lorsqu'elles sont des sujets de recherche. Le présent chapitre abordera successivement chacune de ces questions.

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492 Organisation mondiale de la santé, *Programme d'action globale en santé mentale*, 2002, p. 14.

11.2 LES SOURCES DE FINANCEMENT POUR LA RECHERCHE EN SANTÉ MENTALE AU CANADA

11.2.1 Le rôle fondamental des Instituts de recherche en santé du Canada

Au Canada, la plupart des recherches sur la santé mentale et les toxicomanies sont effectuées par des chercheurs dans des universités et des hôpitaux universitaires, même si elles sont de plus en plus réalisées en collaboration avec des collègues en dehors du milieu universitaire. Le gouvernement fédéral, par le biais des Instituts de recherche en santé du Canada (IRSC), est le principal commanditaire de ces recherches. Les IRSC ont été créés en 2000 à partir de l'ancien Conseil de recherches médicales dans le cadre de l'engagement du gouvernement fédéral de faire du Canada l'une des cinq premières nations en matière de recherche dans le monde.

Les recherches sur la santé de la population et les recherches sur les services de santé demeurent relativement faibles dans les domaines de la santé mentale, de la maladie mentale et des toxicomanies.

Les IRSC ont divisé l'éventail des recherches en santé en 13 secteurs, chacun représenté par un institut. Ces instituts sont des réseaux stratégiques qui recoupent les disciplines et franchissent les frontières géographiques. L'un d'entre eux, l'Institut des neurosciences, de la santé mentale et des toxicomanies (INSMT), est devenu la plaque tournante des recherches sur la santé mentale, les maladies mentales et les toxicomanies au Canada. Il dispose d'un mandat très large : appuyer les recherches sur le cerveau, l'esprit, la moelle épinière, les systèmes sensoriels et moteurs, ainsi que la santé mentale, la maladie mentale et toutes les formes de toxicomanies. L'INSMT collabore également avec les ministères et organismes fédéraux et provinciaux et avec des organisations non gouvernementales pour élaborer et mettre en œuvre des stratégies de recherche et de formation de chercheurs.

Il y a encore beaucoup de choses à apprendre au Canada sur les meilleures pratiques en vue de dispenser des soins et d'apporter un soutien aux personnes atteintes de maladies mentales et de toxicomanies, que ce soit en matière de soins aux malades hospitalisés, de soins en clinique externe, d'interventions d'urgence, de logement, d'emploi ou d'autonomie.

Comme dans le cas des recherches générales sur la santé financées par les IRSC, les recherches sur la santé mentale, la maladie mentale et les toxicomanies englobent tout le spectre d'études allant de services biomédicaux à des services cliniques et sanitaires en passant par des recherches sur la santé de la population. La plupart des témoins ont accueilli avec plaisir l'inclusion des recherches sur la santé de la population et des recherches sur les services de santé dans le mandat des IRSC, domaines d'enquête qui avaient été exclus de la recherche biomédicale qui était le point de mire du Conseil de recherches médicales.

Les recherches sur la santé de la population et les recherches sur les services de santé demeurent relativement faibles dans les domaines de la santé mentale, de la maladie mentale et des toxicomanies. Le D[r] Shitij Kapur et le D[r] Franco Vaccarino, du Centre de toxicomanie et de santé mentale, ont parlé aux membres du Comité de l'importance de remédier à cette

situation étant donné les effets des déterminants plus vastes de la santé sur la maladie mentale et la toxicomanie.[493]

En ce qui concerne la recherche sur les services de santé, un examen de la documentation préparé pour Santé Canada en 1997 a laissé entendre qu'il y a encore beaucoup de choses à apprendre au Canada sur les meilleures pratiques en vue de dispenser des soins et d'apporter un soutien aux personnes atteintes de maladies mentales et de toxicomanies, que ce soit en matière de soins aux malades hospitalisés, de soins en clinique externe, d'interventions d'urgence, de logement, d'emploi ou d'autonomie. Même dans les domaines où nous possédons le plus de données portant sur leur efficacité, on note un besoin pressant d'approfondir les éléments qui fonctionnent le mieux auprès d'un certain groupe de la population.[494]

Un article de l'Organisation mondiale de la santé appuie cette constatation, en suggérant qu'il existe de nombreuses lacunes dans la recherche sur la santé mentale.[495] Selon l'OMS,

- il y a eu très peu d'études de suivi à long terme sur l'efficacité;
- les recherches sur le lien entre la santé mentale d'une population et les politiques sociales et économiques publiques font défaut;
- la base d'éléments probants pour certains programmes et stratégies de santé mentale est limitée; et
- les données sur les coûts et avantages relatifs des interventions en santé mentale sont rares.

Le D[r] Rémi Quirion, directeur scientifique de l'INSMT, a déclaré au Comité :

> *Il nous manque beaucoup d'informations précises au pays, en termes d'incidence, de prévalence, de traitements, de qualité de traitement, de transfert de connaissances.*[496]

Il est primordial d'effectuer davantage de recherches approfondies pour générer les résultats nécessaires en vue d'orienter les décisions concernant les destinataires et le lieu du traitement, les traitements à fournir et la façon de

D'importantes lacunes subsistent dans notre compréhension de la santé mentale et de la toxicomanie, lacunes qui ne peuvent être comblées que par l'augmentation des recherches.

493 Kapur, S. et F. Vaccarino. (2004) Des découvertes aux soins : favoriser la recherche sur la maladie mentale et les toxicomanies. Document commandé par le Comité, p. 5.

494 Unité de recherche sur les systèmes de santé, Institut psychiatrique Clarke. (1997) Examen des meilleures pratiques de la réforme des soins de la santé mentale : Document de discussion. Réseau de consultation sur la santé mentale fédérale, provinciale et territoriale, Santé Canada, pp. 27-28.

495 Organisation mondiale de la santé. (Octobre 2004) Conférence européenne sur la santé mentale de l'OMS : relever les défis, trouver des solutions.

496 21 juin 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/23eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

donner une assurance que les soins dispensés sont appropriés aux besoins particuliers des personnes ayant une maladie mentale et/ou une toxicomanie.

Le Comité reconnaît le rôle du gouvernement fédéral dans la création des IRSC et sa décision de créer l'INSMT, ainsi que les contributions du Dr Rémi Quirion, directeur scientifique de l'INSMT. Des progrès considérables ont été réalisés dans la promotion et la réalisation de recherches sur la santé mentale, la maladie mentale et la toxicomanie. Néanmoins, les membres du Comité partagent les inquiétudes de l'INSMT à l'effet que d'importantes lacunes subsistent dans notre compréhension de la santé mentale et de la toxicomanie, lacunes qui ne peuvent être comblées que par l'augmentation des recherches.

À l'heure actuelle, l'INSMT est engagé dans un exercice d'établissement des priorités, en demandant les commentaires des intervenants pour élaborer son deuxième plan quinquennal. Aux yeux des membres du Comité, ce processus est encourageant. Les membres du Comité tiennent à faire remarquer qu'ils recommandent au Chapitre 10 du présent rapport que les IRSC élaborent un courant de financement centré sur la recherche portant sur l'autonomie et le soutien des pairs, domaines de traitement et de rétablissement relativement nouveaux et prometteurs.

11.2.2 Le financement fédéral de la recherche sur la santé mentale

Les IRSC sont le principal commanditaire public de la recherche sur la santé mentale et la toxicomanie au Canada. En 2004-2005, ils ont affecté au total 53,7 millions $ à la recherche sur la santé mentale et la toxicomanie de leur budget global d'environ 700 millions $.[497] Les IRSC ont dépensé 98 millions $ de plus pour la recherche sur les neurosciences fondamentales, ainsi que sur tous les aspects de la recherche clinique, sur les services de santé et sur la population en rapport avec les maladies et les troubles neurologiques des sens.

Environ 60 p. 100 de ces fonds ont été attribués par le biais de l'INSMT; le reste ayant été affecté par l'intermédiaire d'autres instituts comme les Instituts sur la santé des autochtones, la santé des femmes et des hommes, les services et les politiques de la santé, la santé publique et des populations et la génétique. Comme dans le cas de toutes les ressources des IRSC, ces fonds ont été attribués en réponse à des demandes qui ont été financées sur la base du mérite scientifique tel qu'évalué par le processus international d'examen par les pairs des IRSC. Environ 30 p. 100 de ces fonds ont été attribués par suite d'initiatives stratégiques des IRSC.[498]

En plus des IRSC, deux autres sources de financement fédéral pour la recherche sur la santé mentale sont le Conseil de recherches en sciences humaines (CRSH) et le Conseil de recherches en sciences naturelles et en génie (CRSNG). Le CRSH appuie la recherche dans le vaste domaine de la psychologie sociale et le CRSNG finance des projets ayant trait aux

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497 Selon le Rapport sur les plans et priorités 2005-2006 des IRSC, ses dépenses globales pour 2005-2006 atteindront 811,7 millions $. Cependant, des dirigeants des IRSC ont déclaré devant le Comité que cela inclut les fonds de transfert pour les programmes des chaires de recherche du Canada et les réseaux de centres d'excellence.

498 Quirion, R. (21 juin 2005) Témoignage devant le Comité sénatorial permanent des affaires sociales, des sciences et de la technologie. Voir aussi : Instituts de recherche en santé du Canada. Rapport sur les plans et les priorités 2005-2006.

processus psychologiques fondamentaux, à leurs mécanismes neuronaux sous-jacents, à leur développement au sein des individus et à leur contexte évolutif et écologique. Ni le CRSH, ni le CRSNG ne fournissent des fonds importants pour la recherche sur la santé mentale. Ensemble, ils ont versé environ 6 millions $ à la recherche sur la santé mentale en 2002-2003.[499]

D'autres sources fédérales de fonds pour la recherche sur la santé mentale et la toxicomanie peuvent inclure Statistique Canada, la Stratégie canadienne anti-drogues (qui finance le Centre canadien de lutte contre les toxicomanies), Santé Canada, le Service correctionnel Canada (Centre de recherche en toxicomanie) et la Fondation canadienne de la recherche sur les services de santé. Le Comité n'a pas obtenu de renseignements sur les niveaux de financement fourni par ces sources.

Nous reviendrons plus loin sur la question de savoir si oui ou non le niveau de financement du gouvernement fédéral est adéquat après avoir examiné la disponibilité de fonds pour la recherche sur la santé mentale provenant d'autres sources.

11.2.3 Autres sources de financement pour la recherche sur la santé mentale

L'industrie pharmaceutique est la plus importante source individuelle de financement pour la recherche sur la santé au Canada. On ne sait pas au juste quelle part de ce financement de la recherche par l'industrie pharmaceutique au Canada va à la santé mentale et à la toxicomanie, mais on pense que c'est une somme considérable.

Les découvertes pharmaceutiques constituent un produit important de la recherche sur les maladies mentales, parce que les médicaments sont un élément essentiel des options de traitement des personnes atteintes d'une maladie mentale. De fait, l'industrie pharmaceutique est la plus importante source individuelle de financement pour la recherche sur la santé au Canada. En 2004, elle a investi 1,6 milliard $ en recherche et développement sur la santé, soit environ 27 p. 100 du total consacré à la recherche sur la santé au pays.[500] On ne sait pas au juste quelle part de ce financement de la recherche par l'industrie pharmaceutique au Canada va à la santé mentale et à la toxicomanie, mais on pense que c'est une somme considérable. En raison de la forte présence de l'industrie privée dans ce domaine, le gouvernement fédéral n'est pas un commanditaire important de la recherche sur les thérapies pharmaceutiques pour la maladie mentale. Cependant, reconnaissant l'importance de fournir une aide aux chercheurs pour mettre les découvertes en pratique, les IRSC offrent effectivement des fonds pour les activités de commercialisation.

Dans la plupart des provinces, les organes gouvernementaux octroient des fonds pour appuyer la recherche sur la santé mentale et la toxicomanie (par ex. le Fonds de la recherche en santé du Québec, la Fondation ontarienne de la santé mentale, le Conseil manitobain de la recherche en matière de santé, le Centre de toxicomanie et de santé mentale (Toronto), etc.).

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499 Comité sénatorial permanent des affaires sociales, des sciences et de la technologie. (Novembre 2004) Rapport 1- Santé mentale, maladie mentale et toxicomanie : Aperçu des politiques et des programmes au Canada, Chapitre 10, p. 221.

500 Statistique Canada. (Juillet 2005) Estimation des dépenses totales au titre de la recherche et du développement dans le secteur de la santé au Canada, 1988 à 2004. Statistique des sciences, Bulletin de service, N° de cat. 88-001-XIE, Vol. 29, N° 5.

Ces organismes fournissent environ 10 millions $ par an, contribution importante à la recherche sur la santé mentale et la toxicomanie, mais nettement inférieure au financement des Instituts de recherche en santé du Canada.

En outre, de nombreux organismes bénévoles de santé (OBS), comme des œuvres de bienfaisance et des fondations, peuvent répondre efficacement aux besoins de soutien de différents groupes de personnes vivant avec une maladie mentale ou une toxicomanie. Cependant, ces OBS sont rarement en mesure de trouver des fonds suffisants pour commanditer des recherches sur les troubles spécifiques qu'ils ciblent.

De plus, il existe seulement deux organismes nationaux sans but lucratif ayant pour mandats spécifiques de recueillir de l'argent pour financer la recherche sur la santé mentale et la toxicomanie : la Fondation canadienne de la recherche en psychiatrie (environ 1,1 million $ par an) et NeuroScience Canada (160 000 $ pour la recherche sur la santé mentale et la toxicomanie en 2004).[501]

Le stigmate associé à la maladie mentale et à la toxicomanie dresse des obstacles importants en vue d'attirer une publicité convenable, d'obtenir des commandites corporatives et de recueillir des fonds pour le soutien de la recherche. Cette expérience contraste avec celle des autres groupes de maladies,

D'autres OBS recueillent des fonds presque exclusivement pour le soutien et le traitement des patients. Parmi eux, la Société canadienne de schizophrénie a financé au total 11 bourses de recherche depuis 1994 grâce aux produits du fonds de dotation en capital de 1,5 million $ constitué par le don du défunt D[r] Michael Smith de la moitié de sa récompense pour le prix Nobel 1993.[502]

La Fondation canadienne de la recherche en psychiatrie (FCRP) a déclaré devant le Comité que le stigmate associé à la maladie mentale et à la toxicomanie dresse des obstacles importants en vue d'attirer une publicité convenable, d'obtenir des commandites corporatives et de recueillir des fonds pour le soutien de la recherche. Cette expérience contraste avec celle des autres groupes de maladies, comme le cancer et les maladies cardiovasculaires, pour lesquels les organismes respectifs de bienfaisance dans le domaine de la santé sont forts et réussissent à trouver des bailleurs de fonds et des partisans pour la recherche :

> *La Fondation relève un défi de taille en voulant sensibiliser la population au problème des maladies mentales et recueillir des fonds de recherche pour trouver les causes de diverses maladies mentales, leurs traitements et finalement, leurs remèdes. Malheureusement, le caractère honteux de la maladie mentale persiste. Par conséquent, des millions de personnes souffrent en silence d'un désespoir inimaginable, craignant que la révélation de leur maladie n'entraîne des conséquences néfastes sur le plan personnel. Dans ces conditions, on ne prend guère conscience des maladies mentales, on les comprend mal, les mécanismes de soutien sont*

501 Ces renseignements ont été obtenus sur les sites web des organismes : www.cprf.ca et www.neurosciencecanada.ca.

502 Consultez le site web de la Société canadienne de schizophrénie www.schizophrenia.ca.

peu nombreux, les fausses conceptions sont répandues et le financement essentiel à la recherche est dangereusement bas.[503]

Étant donné la difficulté rencontrée par les OBS pour recueillir des fonds, le Comité recommande :

53	**Que la Commission canadienne de la santé mentale (voir le Chapitre 16) collabore avec des organismes de santé non gouvernementaux pour développer et renforcer leur capacité de financement afin de recueillir davantage de fonds pour la recherche sur la santé mentale et la toxicomanie.**

Le gouvernement fédéral pourrait accroître le montant des fonds disponibles pour établir des partenariats stratégiques avec les secteurs privé et sans but lucratif. Patrick McGrath, titulaire de la Chaire de recherche du Canada sur la douleur chez l'enfant, a déclaré au Comité :

Je pense qu'il faudrait aider les IRSC [pour obtenir plus d'argent pour la recherche sur la santé mentale] à se trouver des partenaires, par exemple, pour augmenter l'enveloppe budgétaire. Il n'y a pas assez d'argent pour la recherche en santé au Canada. Même si la situation s'est beaucoup améliorée, nous sommes toujours parmi les trois pays du G8 les moins généreux à ce titre. Ce n'est pas que les IRSC ont beaucoup d'argent et qu'ils n'auraient qu'à cibler ce champ de recherche. Bien entendu, il serait bon que les IRSC réservent des fonds, mais je pense qu'il serait encore plus utile de collaborer avec les IRSC et de faire augmenter l'enveloppe budgétaire.[504]

De fait, le principal organisme sans but lucratif qui finance la recherche sur la santé mentale, la Fondation canadienne de la recherche en psychiatrie, a déclaré devant le Comité qu'elle souhaite établir davantage de partenariats avec les IRSC. Le Comité est d'avis qu'on pourrait dire la même chose du secteur privé. Même si les IRSC se lancent déjà dans des activités de partenariat, elles pourraient être augmentées. Par conséquent, le Comité recommande :

54	**Que les Instituts de recherche en santé du Canada cherchent activement d'autres possibilités de partenariats en recherche sur la santé mentale et la toxicomanie avec les secteurs privé et sans but lucratif.**

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503 Fondation canadienne de la recherche en psychiatrie. (Juin 2003) Mémoire soumis au Comité sénatorial permanent des affaires sociales, des sciences et de la technologie, p. 2.

504 10 mai 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/15evd-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

En plus de financer la recherche, les organismes bénévoles peuvent également jouer un rôle consultatif important en matière de recherche sur la santé mentale, la maladie mentale et la toxicomanie au Canada. Le Dr Quirion a déclaré au Comité que, dès la création de l'INSMT, il a recherché et favorisé la collaboration avec 60 organismes bénévoles et sans but lucratif. Ces groupes ont participé à la rédaction du plan stratégique de l'Institut et à l'élaboration d'une stratégie permettant d'aller chercher plus de financement.[505]

Les organismes bénévoles peuvent également jouer un rôle consultatif important en matière de recherche sur la santé mentale, la maladie mentale et la toxicomanie au Canada.

Des personnes ayant une maladie mentale, des membres de leur famille et des représentants d'OBS ont fait part au Comité de leur désir de prendre part au processus de recherche. Ils sont bien placés pour lutter contre le manque de compréhension persistant et la stigmatisation associés à la maladie mentale mais se sentent déconnectés du milieu de la recherche. Ainsi, ils pourraient participer, le cas échéant, à la formulation de questions de recherche et leurs représentants pourraient siéger aux comités d'examen. Cela permettrait aux chercheurs d'être mieux à même de faire les recherches les plus urgentes en santé mentale et en toxicomanie. Élément important, leur participation renforcerait l'aspect humain de la science et serait là pour leur rappeler la nécessité d'une application pratique des bienfaits de la recherche.[506] Le Comité recommande donc :

55	**Que les Instituts de recherche en santé du Canada officialisent l'implication des organismes non gouvernementaux de santé, des personnes ayant une maladie mentale et des membres de leur famille dans l'établissement des priorités de recherche sur la santé mentale et au niveau de la participation aux comités d'examen par les pairs.**

11.2.4 Un financement ciblé est nécessaire

> *(…) le financement actuel de la recherche en MTT est insuffisant au Canada. En termes relatifs comme absolus, cette recherche est sous-financée. Si on ajoute à ce sous-financement systémique l'impact de l'ostracisme, les limites des levées de fonds publiques des ONG dans ce domaine ainsi que le manque d'incitatifs commerciaux pour beaucoup de ces activités, le sous-financement devient encore plus criant. Comme ces contraintes sont difficiles à infléchir, il est d'autant plus essentiel que le gouvernement fédéral fasse preuve de leadership en garantissant un*

505 6 mai 2003, http://www.parl.gc.ca/37/2/parlbus/commbus/senate/com-f/soci-f/14eva-f.htm?Language=F&Parl=37&Ses=2&comm_id=47.

506 Gray, J., président, Société canadienne de schizophrénie. (12 mai 2004) Mémoire soumis au Comité sénatorial permanent des affaires sociales, des sciences et de la technologie, p. 3.

financement juste à la recherche sur la MMT. – Dr Shitij Kapur et Dr Franco Vaccarino

La prévalence de la maladie mentale et de la toxicomanie est élevée au Canada et le fardeau économique est énorme. Une étude portant sur le fardeau global de la maladie mentale estime qu'elle représente 15,4 p. 100 du fardeau des maladies dans les économies de marché établies, dépassé seulement par les maladies cardiovasculaires (à 18 p. 100);[507] il y a presque autant de personnes qui luttent contre la dépression que celles qui ont des maladies cardiovasculaires. Le fardeau total direct et indirect de la maladie mentale pour l'économie canadienne a été estimé à 14,4 milliards $ en 1998.[508]

Le pourcentage des sommes investies dans la recherche sur la santé qui est affecté à la santé mentale, à la maladie mentale et à la toxicomanie est malheureusement inadéquat. Pour réaliser des progrès il faut accorder un niveau adéquat de financement.

De nombreux témoins ont affirmé avec raison que l'énorme fardeau de la maladie mentale et de la toxicomanie sur la société devrait se traduire directement au niveau du financement accordé à la recherche sur la santé mentale, la maladie mentale et la toxicomanie. Cependant, plusieurs témoins ont déclaré au Comité qu'en appliquant ce principe, le pourcentage des sommes investies dans la recherche sur la santé qui est affecté à la santé mentale, à la maladie mentale et à la toxicomanie est malheureusement inadéquat. Le Dr Quirion, directeur scientifique de l'INSMT, a déclaré devant le Comité :

> *Nous sommes d'accord qu'il n'y a pas suffisamment d'investissement pour la recherche en santé mentale au Canada, comparativement aux coûts socio-économiques qui sont associés à ces maladies… Si nous considérons ce que nous appelons le fardeau de la maladie, le coût qu'il représente pour la société et l'incidence des maladies mentales, le Canada, par l'intermédiaire des Instituts canadiens de recherche en santé, doit investir davantage dans la recherche en santé mentale.*[509]

Le gouvernement fédéral, par le biais des IRSC, doit accorder à la recherche sur la maladie mentale et la toxicomanie une priorité supérieure à celle dont elle jouit à l'heure actuelle.

Le Comité est d'avis que la recherche dans ces domaines est extrêmement importante et qu'elle peut aboutir à des améliorations considérables dans la vie des gens atteints de maladie mentale et de toxicomanie au Canada. Cependant, pour réaliser des progrès il faut accorder un niveau adéquat de financement. Le Comité s'inquiète que des ressources

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507 Murray, C. et A. Lopez. (1996) The Global Burden of Disease: A comprehensive assessment of mortality and disability from diseases, injuries and risk factors in 1990 and projected to 2020. Harvard University Press.

508 Comité sénatorial permanent des affaires sociales, des sciences et de la technologie. (Novembre 2004) Rapport 1—Santé mentale, maladie mentale et toxicomanie : Aperçu des politiques et des programmes au Canada, Chapitre 5, p. 101.

509 21 juin 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/23eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

adéquates ne sont pas accordées spécifiquement à la recherche concernant la maladie mentale et la toxicomanie, en particulier en raison de leur fardeau économique et social sur la société canadienne.

Pour résumer, les IRSC constituent la principale source de fonds disponibles au Canada pour la recherche sur la santé mentale, la maladie mentale et la toxicomanie. Les fonds privés sont surtout consacrés aux innovations pharmaceutiques et les organismes provinciaux ne sont pas bien financés. En outre, en raison de la stigmatisation associée à la maladie mentale et à la toxicomanie, la capacité des organisations non gouvernementales de recueillir des fonds pour financer la recherche sur la maladie mentale et la toxicomanie est nettement inférieure à celle des autres principaux domaines de la santé, comme les maladies du cœur, le cancer, le diabète et l'arthrite. Le Comité est donc fortement d'avis que le gouvernement fédéral, par le biais des IRSC, doit accorder à la recherche sur la maladie mentale et la toxicomanie une priorité supérieure à celle dont elle jouit à l'heure actuelle.

Le Comité appuie fermement les travaux réalisés par les IRSC dans leur ensemble, et par l'INSMT en particulier. Même si le Comité pourrait demander aux IRSC de réaffecter des ressources à l'interne, cela signifierait prélever des ressources d'autres secteurs importants de la santé et priver potentiellement de fonds nécessaires des milieux de recherche naissants. Le Comité est plutôt d'avis qu'il faudrait accorder des fonds supplémentaires croissants aux IRSC dans le but de financer davantage de recherches sur la santé mentale, la maladie mentale et la toxicomanie.

Il faudrait accorder des fonds supplémentaires croissants aux IRSC dans le but de financer davantage de recherches sur la santé mentale, la maladie mentale et la toxicomanie. Il faudrait attribuer des sommes supplémentaires dans un fonds spécialisé, selon la même démarche que le financement de la recherche sur le VIH/sida que le gouvernement fédéral octroie déjà aux IRSC.

L'INSMT a un mandat très large et dessert un très vaste milieu de la recherche. Le Comité s'inquiète qu'en augmentant simplement les fonds accordés à l'INSMT, on pourrait engager davantage de fonds pour appuyer la recherche dans des domaines comme les neurosciences au lieu de les consacrer à la recherche sur les domaines beaucoup moins bien financés, comme les facteurs psychologiques et sociaux associés à la maladie mentale et à la toxicomanie, qui en ont bien besoin. Le Comité est donc d'avis qu'il faudrait attribuer des sommes supplémentaires dans un fonds spécialisé, selon la même démarche que le financement de la recherche sur le VIH/sida que le gouvernement fédéral octroie déjà aux IRSC.

En outre, tel que mentionné précédemment, les domaines de la recherche clinique, de la recherche sur la santé de la population et de la recherche sur les services de santé demeurent faibles dans les secteurs de la santé mentale, de la maladie mentale et de la toxicomanie. Il est crucial que des efforts soient déployés pour combler les lacunes importantes au niveau de notre compréhension de ces domaines, même si on doit commencer en remontant dans le processus de recherche jusqu'au recrutement et à la formation de chercheurs de haut calibre. Un autre facteur à ne pas oublier, tel que mentionné dans la section précédente du présent rapport, est l'importance d'impliquer les intervenants dans le processus décisionnel d'établissement des priorités de la recherche. Le Comité recommande donc :

56	**Que le gouvernement du Canada engage 25 millions de dollars par an pour la recherche sur les aspects de la santé mentale, de la maladie mentale et de la toxicomanie touchant les essais cliniques, les services de santé et la santé de la population.** **Que ces fonds soient administrés par les Instituts de recherche en santé du Canada (IRSC), par le biais de l'Institut des neurosciences, de la santé mentale et des toxicomanies sous l'autorité d'un conseil multilatéral et en consultation avec la Commission canadienne de la santé mentale (voir le Chapitre 16).** **Que ces 25 millions de dollars s'ajoutent au financement actuellement fourni aux IRSC.**

Le budget total des IRSC affectera également les fonds mis à la disposition de secteurs spécifiques, dont la santé mentale et la toxicomanie. Dans son rapport de 2002 sur l'état du système de soins de santé au Canada, le Comité avait demandé une augmentation de la contribution annuelle du gouvernement fédéral à la recherche sur la santé de 1 p. 100 des dépenses totales consacrées aux soins de santé.[510] Pour atteindre cet objectif cette année, il faudrait ajouter 700 millions $ au budget annuel des IRSC actuellement à 1,3 milliard $.

Même si le Comité est encouragé par les hausses importantes du financement fédéral accordé aux IRSC au début de son existence, ce soutien est essentiellement demeuré au plateau de 0,5 p. 100 du total des dépenses de santé au cours des dernières années. Le Comité réitère son appui ferme en vue d'atteindre l'objectif de 1 p. 100 et recommande :

57	**Que le gouvernement du Canada, dans un laps de temps raisonnable, augmente son financement de la recherche en santé de façon à atteindre le niveau de 1 % des dépenses totales consacrées aux soins de santé.**

Un certain nombre de mémoires présentés au Comité ont également souligné l'importance de la capacité, et certains témoins ont insisté sur le fait que des effectifs insuffisants de médecins participent à la recherche sur la santé mentale et la toxicomanie et qu'une lacune majeure demeure le fait que trop peu de cliniciens-chercheurs sont formés pour effectuer des essais cliniques capitaux. Le D[r] Quirion a déclaré devant le Comité :

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[510] Comité sénatorial permanent des affaires sociales, des sciences et de la technologie. (Octobre 2002) La santé des Canadiens — Le rôle du gouvernement fédéral, Vol. 6, Ch. 12.

Nous espérons pouvoir convaincre le CIHR [les IRSC] de réserver une partie de l'enveloppe budgétaire pour la formation, et la recherche clinique de spécialistes de la santé mentale et de la maladie mentale.[511]

Cela ne signifie pas simplement d'intéresser de jeunes chercheurs à la santé mentale mais également de s'assurer que des praticiens cliniciens auront aussi des occasions de faire des recherches. Le Comité partage ces inquiétudes et estime qu'il faudrait consacrer des fonds supplémentaires au recrutement, à l'éducation et à la formation d'un plus grand nombre de chercheurs et de cliniciens-chercheurs afin d'accroître la capacité du Canada en vue d'effectuer des recherches de première classe en santé mentale et en toxicomanie. L'une des priorités du plan stratégique de l'INSMT pour 2001-2005 est la création d'un plus grand nombre de débouchés de formation pour les cliniciens-chercheurs. L'INSMT a déjà mené à bien un certain nombre d'activités dans ce domaine, comme son programme Cerveaux en tête. Cependant, le Comité estime que l'on pourrait et devrait en faire davantage. Le Comité recommande donc :

58	**Que les Instituts de recherche en santé du Canada, par l'intermédiaire de l'Institut des neurosciences, de la santé mentale et des toxicomanies, augmentent les fonds disponibles dans le but précis de recruter et former des chercheurs et d'effectuer des recherches cliniques sur la santé mentale, la maladie mentale et la toxicomanie.**

11.3 DIFFUSION DES RÉSULTATS DE RECHERCHE

Il faudrait prendre des mesures pour s'assurer que l'information concernant les possibilités de financement de la recherche soit communiquée clairement aux chercheurs, pour faciliter la coordination interdisciplinaire et la collaboration dans le milieu de la recherche et pour diffuser largement les résultats de recherche aux dispensateurs de soins de santé, aux personnes atteintes de maladie mentale et aux décideurs.

Une importante préoccupation des chercheurs en santé mentale, maladie mentale et toxicomanie réside dans le fait qu'il n'y a actuellement pas de base de données centrale pour toutes les sources de financement. Il n'y a pas non plus de source d'information autorisée sur le sujet des enquêtes. La Fondation canadienne de la recherche en psychiatrie a fait remarquer qu'il n'y avait aucune coordination entre les organismes de financement de la recherche et aucune responsabilité centrale pour la collecte des données. En conséquence, les chercheurs éprouvent des difficultés à se frayer un chemin non seulement vers les organismes gouvernementaux subventionnaires mais également vers les sources de financement du secteur privé et du secteur sans but lucratif. La mise sur pied d'une base de données centrale contribuerait non seulement à éviter la duplication et les chevauchements, mais elle faciliterait la

[511] 21 juin 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/23eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

communication entre les chercheurs. Elle aiderait également les personnes atteintes de maladie mentale, leurs familles et les organismes bénévoles de santé à connaître les recherches en cours.

Les chercheurs ne sont peut-être pas au courant des recherches effectuées dans d'autres domaines de spécialisation qui peuvent influer sur leurs travaux, surtout étant donné que les problèmes de maladie mentale et de toxicomanie recoupent un large éventail de disciplines. La fourniture de tels renseignements pourrait encourager la collaboration, améliorer la productivité et minimiser l'impact négatif de la concurrence entre les universités et les hôpitaux. La Fondation canadienne de la recherche en psychiatrie a recommandé d'établir une base de données centrale concernant les organismes subventionnaires, y compris les organisations non gouvernementales, un répertoire des sujets étudiés et des lieux de recherche, et un site pour présenter un résumé des résultats de recherche.[512]

Le Royaume-Uni a adopté une approche novatrice pour garantir une meilleure coordination entre les chercheurs en santé mentale. En janvier 2003, le Royaume-Uni a créé le Mental Health Research Network, qui est destiné à fournir une infrastructure pour la recherche en santé mentale.[513] Il agit comme un centre d'information et de référence, en reliant les usagers du service et les dispensateurs de soins avec les chercheurs et les professionnels de la santé mentale. Il abrite des projets de recherche à grande échelle en santé mentale qui exigent des centres multiples et effectue la majorité du travail de gouvernance et des tâches financières et administratives au nom des chercheurs. Le Réseau implique actuellement sept carrefours de recherche qui représentent différentes bases géographiques et culturelles. Les carrefours réunissent des universitaires, des cliniciens et les intervenants de la santé et des soins sociaux.

Le Réseau a été créé parce que les petites études localisées ne permettaient souvent pas aux chercheurs de tirer des conclusions générales valides. En outre, la mauvaise intégration des ressources, de l'expérience et de l'expertise limitait la capacité de certains chercheurs en santé mentale en vue d'obtenir l'appui d'importants organismes de financement. Cela faisait en sorte que les recherches n'arrivaient pas à alimenter la politique publique et manquaient de cohérence, de pertinence et de crédibilité auprès des usagers et des professionnels.

La mise sur pied d'un réseau semblable au Canada demanderait beaucoup de temps et d'efforts et devrait être adaptée aux circonstances canadiennes. Néanmoins, cela devrait demeurer un objectif à long terme.

Entre-temps, il serait peut-être possible d'en adopter certains éléments. En particulier, il faudrait prendre des mesures pour s'assurer que l'information concernant les possibilités de financement de la recherche soit communiquée clairement aux chercheurs, pour faciliter la coordination interdisciplinaire et la collaboration dans le milieu de la recherche et pour diffuser largement les résultats de recherche aux dispensateurs de soins de santé, aux personnes atteintes de maladie mentale et aux décideurs.

L'Institut des neurosciences, de la santé mentale et des toxicomanies s'efforce actuellement de favoriser l'échange de renseignements et de connaissances entre les chercheurs, mais pas

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512 Fondation canadienne de la recherche en psychiatrie. (Juin 2003) Mémoire présenté au Comité sénatorial permanent des affaires sociales, des sciences et de la technologie, p. 9.

513 Consultez le site web du Mental Health Research Network : http://www.mhrn.info/.

de façon systématique. Les membres du Comité sont d'avis que le travail de diffusion serait accompli au mieux par un organisme capable de jeter des ponts entre les divers paliers de gouvernement, les organisations non gouvernementales et les établissements de recherche. Le Comité recommande donc :

50	**Que le Centre d'échange des connaissances créé par la Commission canadienne de la santé mentale (voir le Chapitre 16) comprenne, entre autres choses, une base de données sur Internet d'organismes et de possibilités de financement de la recherche, dans laquelle seraient indiqués les sujets et les lieux des recherche et, sous forme résumée, les résultats de recherche de tous les ordres de gouvernement, des universités et des organisations non gouvernementales.** **Que le Centre d'échange des connaissances contribue également à la mise en commun des renseignements en organisant des conférences, des ateliers et des sessions de formation sur la recherche en santé mentale.**

11.4 APPLICATION DES CONNAISSANCES

L'application des connaissances consiste à transformer les connaissances obtenues par la recherche en services et en produits plus efficaces et, par exemple, en un système plus solide et plus efficace de santé mentale. Elle implique davantage que la diffusion de l'information entre les chercheurs; l'application des connaissances implique d'établir un lien entre la recherche fondamentale et la pratique clinique. Le D[r] Ashok Malla, chef de la recherche à l'Hôpital Douglas (Montréal), a déclaré devant le Comité :

L'application des connaissances consiste à transformer les connaissances obtenues par la recherche en services et en produits plus efficaces et, par exemple, en un système plus solide et plus efficace de santé mentale.

> *Nous devons définir l'axe à suivre pour transférer les connaissances en dispensant une formation appropriée. Par exemple, il nous faut effectuer des études dans le domaine de l'intervention précoce, études auxquelles devra prendre part le secteur des soins primaires afin que nous puissions enseigner à ces gens-là comment reconnaître très tôt la maladie mentale et voir si nous pouvons ensuite transférer cette connaissance de façon générale.*[514]

Et Mme Downey, directrice générale de l'Organisation nationale de la santé autochtone, a souligné la nécessité d'adapter l'application des connaissances sur un plan culturel :

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514 16 février 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/22evc-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

> *Le lien qui existe entre l'application des connaissances et la nécessité d'une prestation culturellement adaptée de services et de soutien est reconnu par de nombreuses communautés. Nous savons que les modes de prestation des soins de santé que l'on retrouve dans la société en général répondent à certains besoins mais pas à tous les besoins des peuples autochtones. Nous savons que les initiatives des 25 ou 30 dernières années destinées aux communautés autochtones n'ont pas produit les résultats escomptés. Nous savons en outre que certaines des données sur la santé des Autochtones sont plus navrantes que jamais auparavant.... Il est nécessaire de mener directement auprès des communautés des recherches sur l'application des connaissances afin de mesurer l'incidence de la qualité des services de soins de santé ainsi que les effets de la disponibilité et de l'utilisation de techniques de recherche de pointe pour la programmation communautaire.*[515]

Sans une application effective des connaissances, les traitements inefficaces préjudiciables se poursuivent, alors que des traitements efficaces fondés sur des preuves ne peuvent pas être adoptés par les décideurs et les prestataires de services de santé mentale.

La diffusion et l'application des découvertes demeurent d'importants défis qui ne seront relevés que grâce à des investissements supérieurs.

Le transfert d'une nouvelle idée ou d'une découverte vers la pratique acceptée comporte trois phases distinctes. La première est la découverte fondamentale qui identifie, par exemple, une nouvelle association génétique, une nouvelle méthode de dispenser des soins, une nouvelle façon d'engager les patients dans la thérapie ou une nouvelle idée pour utiliser un traitement établi. La deuxième phase est la validation du principe, la phase d'essais cliniques, qui implique d'appliquer cette découverte à des soins et de démontrer qu'elle fonctionne dans un cadre contrôlé. La troisième phase, celle de dissémination et d'application, implique d'incorporer la nouvelle pratique dans le continuum préexistant des soins et dans le milieu.[516]

L'application des connaissances est d'une importance capitale pour s'assurer que les personnes atteintes de maladie mentale ou de toxicomanie aient accès aux traitements les plus efficaces identifiés par la recherche.

Eric Latimer, économiste de la santé à l'Hôpital Douglas, a déclaré devant le Comité que la recherche sur la maladie mentale et la toxicomanie a connu de nombreux succès au niveau des découvertes, étant donné le financement et le nombre de chercheurs impliqués, mais que

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515 21 avril 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/13evb-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

516 Kapur et Vaccarino (2004), p. 6.

la diffusion et l'application des découvertes demeurent d'importants défis qui ne seront relevés que grâce à des investissements supérieurs.[517]

L'application des connaissances constitue un volet important du mandat des IRSC. L'un de leurs objectifs, tel que mentionné dans la législation qui les crée, vise à exceller «dans la création de nouvelles connaissances et leur application en vue d'améliorer la santé de la population canadienne, d'offrir de meilleurs produits et services de santé et de renforcer le système de santé au Canada, et ce par l'incitation à la diffusion des connaissances et à l'application des résultats de la recherche dans le domaine de la santé en vue d'améliorer la santé de la population canadienne».[518] L'application des connaissances est aussi l'une des trois priorités des IRSC, telles qu'énoncées dans leur *Rapport sur les plans et priorités 2005-2006*.

L'une des priorités stratégiques de l'INSMT consiste à promouvoir les liens et les échanges, par le biais de programmes structurés d'application des connaissances, entre le milieu de la recherche et les paliers municipaux, provinciaux et nationaux de décideurs, ainsi que les usagers des résultats de recherche, incluant les OBS.

Des témoins ont convenu que cet objectif nécessaire et louable ne pourrait pas être atteint avec les niveaux actuels de financement. Durant son témoignage, le professeur Tousignant, du Centre de recherche et intervention sur le suicide et l'euthanasie, a suggéré que les budgets de recherche devraient contenir une part réservée à la «vulgarisation scientifique».[519] Beaucoup d'autres ont déclaré au Comité que l'application des connaissances n'est pas bien faite dans la recherche en santé mentale et en toxicomanie.

Le Comité est d'avis que l'application des connaissances est d'une importance capitale pour s'assurer que les personnes atteintes de maladie mentale ou de toxicomanie aient accès aux traitements les plus efficaces identifiés par la recherche. Par conséquent, le Comité recommande :

60	**Que les Instituts de recherche en santé du Canada (IRSC), par le biais de l'Institut des neurosciences, de la santé mentale et des toxicomanies, accroissent considérablement leurs efforts en matière d'application des connaissances touchant la recherche sur la santé mentale, la maladie mentale et la toxicomanie.** **Que les IRSC collaborent étroitement avec le Centre d'échange des connaissances proposé, afin de faciliter l'échange des connaissances entre les décideurs, les dispensateurs de soins et les groupes de consommateurs.**

517 6 mai 2003, http://www.parl.gc.ca/37/2/parlbus/commbus/senate/com-f/soci-f/14eva-f.htm?Language=F&Parl=37&Ses=2&comm_id=47.

518 Loi sur les Instituts de recherche en santé du Canada, art. 4 *b*).

519 6 mai 2003, http://www.parl.gc.ca/37/2/parlbus/commbus/senate/com-f/soci-f/14eva-f.htm?Language=F&Parl=37&Ses=2&comm_id=47.

11.5 UN PROGRAMME NATIONAL DE RECHERCHE

> *La santé mentale et la maladie mentale sont de la plus haute importance, et le programme national devrait inclure la recherche de pointe. — Rémi Quirion*[520]

Dans le domaine de la santé mentale, de la maladie mentale et de la toxicomanie, il n'y a pas de politique ou de stratégie cohérente en vigueur pour produire une réponse cohérente et coordonnée aux questions pertinentes complexes.

Le Comité a constaté que, dans le domaine de la santé mentale, de la maladie mentale et de la toxicomanie, il n'y a pas de politique ou de stratégie cohérente en vigueur pour produire une réponse cohérente et coordonnée aux questions pertinentes complexes. Habituellement, les troubles mentaux constituent des maladies complexes et chroniques ayant un large impact sur la société. Leurs déterminants recoupent de nombreux secteurs et leur gestion implique de nombreux et différents professionnels de la santé.

Des témoins ont souligné la nécessité de mieux coordonner les efforts actuellement déployés par les gouvernements fédéral et provinciaux, de concert avec les organisations non gouvernementales et l'industrie pharmaceutique, pour relever les nombreux défis posés par la maladie mentale et la toxicomanie. Dans leur document destiné au Comité, le D[r] Kapur et le D[r] Vaccarino ont déclaré :

> *(…) les problèmes de la maladie mentale et de la toxicomanie résistent aux solutions simples. Ces maladies ont de multiples déterminants, d'ordre biologique, psychologique et social, et une réponse acceptable exige la coordination de multiples secteurs. À l'heure actuelle, la recherche dans ces domaines est bien intentionnée mais dépourvue de coordination. Nous réclamons vigoureusement une politique ou un cadre directeur national pour jeter les bases d'un effort coordonné en recherche sur la maladie mentale et la toxicomanie.*[521]

Les témoins ont convenu de la nécessité d'avoir un programme national de recherche.

Les témoins qui ont abordé les questions relatives à la recherche dans le domaine de la santé mentale et de la toxicomanie ont convenu de la nécessité d'avoir un programme national de recherche. À leur avis, un tel programme devrait s'appuyer sur l'expertise canadienne actuelle, coordonner les activités de recherche actuellement fragmentées qui sont effectuées par divers organismes (gouvernements, organisations non gouvernementales, sociétés pharmaceutiques) et garantir un équilibre entre les services biomédicaux,

Une meilleure coordination des activités de recherche bénéficierait aux personnes atteintes de maladie mentale ou de toxicomanie. Il est particulièrement important que la recherche corresponde à leurs besoins.

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520 6 mai 2003, http://www.parl.gc.ca/37/2/parlbus/commbus/senate/com-f/soci-f/14eva-f.htm?Language=F&Parl=37&Ses=2&comm_id=47.

521 Kapur et Vaccarino (2004), p. 11.

cliniques et sanitaires et la recherche sur la santé de la population appliquée à la santé mentale, la maladie mentale et la toxicomanie.

Élément important, de nombreux témoins ont souligné qu'il est grand temps de s'attaquer aux problèmes cruciaux de recherche en santé mentale et en toxicomanie. En particulier, le Dr Quirion a déclaré :

> *En anglais, on dit souvent : «The time is now.» On a vraiment beaucoup d'expertise au Canada à cause du système de santé national. Cela permet d'avoir des collectes de données et des banques de données beaucoup plus impressionnantes que ce qu'il peut y avoir aux États-Unis. Je pense, par exemple, aux nouvelles recherches sur le génome. Je pense qu'on pourrait avoir un impact énorme et on ne devrait pas avoir peur de foncer. Si on fonce avec l'expertise qu'on a présentement, on va réussir à trouver des causes des maladies du cerveau, des maladies mentales.*[522]

Le Comité est d'avis qu'une meilleure coordination des activités de recherche bénéficierait aux personnes atteintes de maladie mentale ou de toxicomanie. Il est particulièrement important que la recherche corresponde à leurs besoins. Étant donné le rôle de chef de file joué par les IRSC dans le financement de la recherche sur la santé au Canada, le Comité recommande :

61	**Que les Instituts de recherche en santé du Canada, par le biais de l'Institut des neurosciences, de la santé mentale et des toxicomanies, collaborent étroitement avec la Commission canadienne de la santé mentale (voir le Chapitre 16), les chercheurs, les organismes provinciaux et non gouvernementaux de financement de la recherche et les organisations représentant les personnes atteintes de maladie mentale ou de toxicomanie, afin d'élaborer un programme national de recherche sur la santé mentale, la maladie et la toxicomanie.**

11.6 SURVEILLANCE

> *La surveillance est nécessaire si l'on veut déterminer l'étendue du problème. Les discussions que la Société canadienne d'autisme a menées avec l'Institut canadien d'information sur la santé, Statistique Canada et Santé Canada ont été frustrantes. Il est reconnu que Santé Canada a le mandat de s'occuper de la surveillance, mais il n'y a pas de volonté politique à cet égard. J'encourage fortement le comité à inciter*

[522] 6 mai 2003, http://www.parl.gc.ca/37/2/parlbus/commbus/senate/com-f/soci-f/14eva-f.htm?Language=F&Parl=37&Ses=2&comm_id=47.

Santé Canada à agir selon son mandat et à assurer la surveillance de tous les troubles de santé mentale et cérébraux. Ce qui est inquiétant, c'est qu'on se contente actuellement d'un projet pilote qui va utiliser des bases de données qui existent déjà, au lieu de bâtir un système permettant la collecte de données nécessaires… Il faut que le ministère fédéral de la Santé assume la responsabilité de la surveillance, ce qui facilitera une meilleure prise de décision. — Lisa Simmermon, directrice des relations publiques, Saskatchewan Families for Effective Austism Treatment[523]

Le Canada ne dispose actuellement d'aucun cliché national de la situation de la santé mentale au pays. Cela veut dire qu'il nous manque une base d'information nationale sur la prévalence de la maladie mentale et de la toxicomanie sous toutes leurs diverses formes. Il nous manque également le système d'information nécessaire pour mesurer la situation de la santé mentale des Canadiens et pour évaluer les politiques, les programmes et les services dans les domaines de la santé mentale, de la maladie mentale et de la toxicomanie. C'est un obstacle important en vue de déterminer le niveau des services de santé mentale et des traitements pour la toxicomanie dont les provinces/territoires et l'ensemble du pays ont besoin et pour évaluer la quantité et la qualité des services offerts actuellement.

La collecte de données de qualité fournira de meilleurs renseignements aux responsables des politiques et aux décideurs, à l'intérieur et à l'extérieur du gouvernement, ainsi qu'aux prestataires de services et aux groupes de consommateurs. Un système de surveillance fournira des mesures que les provinces pourront utiliser pour fixer des objectifs en vue d'atteindre les buts désirés en matière de santé et les résultats souhaités des programmes.

Le Canada ne dispose actuellement d'aucun cliché national de la situation de la santé mentale au pays. La collecte de données de qualité fournira de meilleurs renseignements aux responsables des politiques et aux décideurs, à l'intérieur et à l'extérieur du gouvernement, ainsi qu'aux prestataires de services et aux groupes de consommateurs.

Deux témoins ont parlé au Comité de l'importance d'un système de surveillance. Le D[r] Wade Junek, de l'IWK Health Centre, a insisté sur la nécessité d'avoir de meilleurs systèmes de mesure et d'information.

Si l'objectif fondamental consiste à améliorer la santé mentale de nos jeunes et de nos enfants, ou à la maintenir en l'état, il faut tout d'abord en faire l'évaluation pour déterminer si les mesures prises ont un effet. Il faut avoir des résultats et des évaluations. Deuxièmement, il faut

523 3 juin 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/42454-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

englober cette information relative à ces évaluations dans nos décisions afin de permettre des mesures correctives.[524]

Doug Crossman, gestionnaire des Services de santé mentale à la South Shore District Health Authority en Nouvelle-Écosse, a déclaré aux membres du Comité qu'il est important d'avoir une orientation relativement aux résultats.

> *Nous avons besoin de meilleurs systèmes d'information et de meilleurs systèmes de surveillance de la population pour surveiller ce que nous faisons et offrir une orientation relativement aux résultats. Souvent, nous ne parlons pas de résultats. Nous parlons d'utilisation du service, ce qui signifie que la demande de notre service a augmenté et, donc, que nous aurons besoin de plus d'argent l'an prochain pour offrir plus de services. Nous devrions nous concentrer sur ce que nous faisons pour améliorer la santé globale de la population plutôt que d'élargir l'industrie des services.*[525]

Des données sur les questions de santé mentale et de toxicomanie sont recueillies en permanence par des organismes fédéraux. En voici quelques exemples.

Le Canada ne recueille pas en permanence à l'heure actuelle de données sur la prévalence de la maladie mentale et de la toxicomanie chez les peuples autochtones, les sans-abri et la population carcérale — groupes qui sont à risques plus élevés que la population en général pour les troubles mentaux. En outre, les données sur l'hospitalisation et la mortalité excluent la majorité des personnes qui vivent en dehors des hôpitaux et qui sont traitées pour leur maladie mentale ou leur toxicomanie.

- L'Institut canadien d'information sur la santé (ICIS) recueille des renseignements sur les hospitalisations dans les établissements de soins intensifs et les centres psychiatriques.
- Statistique Canada recueille des renseignements sur la mortalité, y compris des statistiques sur le suicide.
- L'Enquête nationale sur la santé de la population comporte des questions sur l'alcoolisme, le stress, le soutien social, une échelle de détresse et une échelle de dépression.

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524 10 mai 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/15evd-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

525 9 mai 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/15evb-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

- L'Enquête longitudinale nationale sur les enfants et les jeunes comporte des questions sur la santé mentale et la maladie mentale pour une cohorte d'enfants à travers le pays.[526]

Même si certaines des données pourraient servir d'assise à un système de surveillance, chacune des sources de données pertinentes a ses limites. Un autre désavantage grave est leur vision étroite — elles ne fournissent pas une perspective complète sur la santé mentale et la toxicomanie au Canada.

En 2002, l'Enquête sur la santé dans les collectivités canadiennes, réalisée par Statistique Canada, a fourni pour la première fois les taux de prévalence de certaines maladies mentales, les troubles dus à la toxicomanie, les idées suicidaires et le jeu pathologique. Toutefois, le Canada ne recueille pas en permanence à l'heure actuelle de données sur la prévalence de la maladie mentale et de la toxicomanie chez les peuples autochtones, les sans-abri et la population carcérale — groupes qui sont à risques plus élevés que la population en général pour les troubles mentaux. En outre, les données sur l'hospitalisation et la mortalité excluent la majorité des personnes qui vivent en dehors des hôpitaux et qui sont traitées pour leur maladie mentale ou leur toxicomanie.

L'Alliance canadienne pour la maladie et la santé mentale préconise la mise sur pied d'un système national de surveillance qui pourrait être utilisé pour planifier, mettre en œuvre et évaluer les politiques, les services et les programmes. L'Agence de santé publique du Canada a identifié récemment la santé mentale et la maladie mentale comme un domaine prioritaire et a décidé d'accroître la surveillance de la maladie mentale par l'élaboration d'un programme national de surveillance de la maladie mentale. Elle dépensera 400 000 $ au cours des deux prochaines années pour un processus de consultation et un certain nombre d'études de faisabilité et de projets pilotes. Elle vise à proposer un système national de surveillance de la maladie mentale d'ici mars 2007.[527]

L'Alliance canadienne pour la maladie mentale et la santé mentale vise à proposer un système national de surveillance de la maladie mentale d'ici mars 2007.

Le Comité appuie les mesures initiales prises par l'Agence de santé publique. Cependant, il y a encore du pain sur la planche pour brosser un tableau complet de la situation de la santé mentale au Canada. Les membres du Comité sont très préoccupés par le fait que la portée et le rythme anticipés du projet proposé ne sont peut-être pas suffisants. En conséquence, le Comité recommande :

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526 Stewart, P. (2000) The Development of a Canadian Mental Illness and Mental Health Surveillance System: A Discussion Paper — Rapport final. Rédigé pour l'Alliance canadienne pour la maladie et la santé mentales.

527 Mao, Y., directeur, Agence de santé publique. (2005) Présentation à l'atelier sur l'élargissement de la surveillance de la maladie mentale au Canada, 23-24 mars.

62	**Que l'Agence de santé publique poursuive ses efforts en vue d'élaborer en temps voulu un système national complet de surveillance de la maladie mentale qui incorpore les clauses appropriées en matière de protection de la vie privée.** **Que l'Agence de santé publique élargisse la portée des données recueillies de concert avec d'autres organismes, comme l'Institut canadien d'information sur la santé et Statistique Canada, ainsi qu'avec d'autres ordres de gouvernement et organismes qui recueillent des données pertinentes.** **Que, pour la mise sur pied d'un système national complet de surveillance de la maladie mentale, l'Agence de santé publique collabore avec la Commission canadienne de la santé mentale (voir le Chapitre 16).**

11.7 RECHERCHE SUR DES SUJETS HUMAINS

La recherche impliquant des participants humains doit être conçue et exécutée conformément aux normes scientifiques et éthiques les plus élevées et doit protéger la dignité des personnes et de leurs familles qui font cette contribution inestimable au progrès scientifique.

Le Comité appuie fortement la recherche sur la maladie mentale et la toxicomanie parce qu'elle peut jeter les bases de progrès futurs en matière de traitement et de prévention. Cependant, la recherche impliquant des personnes pose de nombreux risques : abus, mauvais usage, exploitation, atteintes à la vie privée, confidentialité, etc. La recherche impliquant des participants humains doit être conçue et exécutée conformément aux normes scientifiques et éthiques les plus élevées et doit protéger la dignité des personnes et de leurs familles qui font cette contribution inestimable au progrès scientifique.

Le Comité reconnaît que les personnes atteintes de maladie mentale et de toxicomanie sont des sujets de recherche particulièrement vulnérables. Même si tous les sujets de recherches cliniques sont vulnérables à un certain degré, la vulnérabilité des personnes participant à des recherches cliniques sur la maladie mentale et la toxicomanie justifie une attention particulière. Il est extrêmement important de protéger les droits et le bien-être de ces personnes qui participent à des recherches et de promouvoir une recherche responsable sur le plan déontologique.

Les progrès de la recherche ne devraient pas être poursuivis aux dépens des droits de la personne et de la dignité humaine. Les garde-fous ne devraient pas non plus être sévères au point d'exclure potentiellement cette population vulnérable de recherches extrêmement importantes qui pourraient améliorer les connaissances scientifiques sur leurs conditions et même leur être bénéfiques en tant que personnes.

Dans le but de garantir la conduite éthique des recherches impliquant des sujets humains, les institutions recevant des fonds de recherche des trois organismes subventionnaires fédéraux — les Instituts de recherche en santé du Canada (IRSC), le Conseil de recherches en sciences naturelles et en génie (CRSNG) et le Conseil de recherches en sciences humaines (CRSH) — sont tenus de respecter l'Énoncé de politique de 1998 des trois Conseils sur l'éthique de la recherche avec des êtres humains (ÉPTC). L'Énoncé précise que les projets de recherche devraient être examinés par un Comité d'éthique en recherche chargé de protéger la sécurité, la vie privée et la dignité des sujets de recherche. Il faut minimiser les risques concernant le bien-être physique ou mental des participants et il faut trouver un juste équilibre entre de tels risques et les avantages pour les participants ou l'ensemble de la société.[528]

Un élément important de l'ÉPTC veut que la recherche impliquant des êtres humains doit être entreprise seulement si les sujets donnent leur consentement libre et éclairé à leur participation à la recherche.[529] Étant donné que la plupart des personnes ayant une maladie mentale fonctionnent raisonnablement bien, elles seront en mesure de donner ou de retirer en toute liberté et en toute lucidité leur consentement en vue de participer à des recherches. Toutefois, dans certaines circonstances, la capacité cognitive des personnes atteintes d'une maladie mentale peut être altérée, ce qui nuit à leur aptitude à prendre des décisions.

L'ÉPTC souligne l'importance du consentement volontaire et comporte des clauses pour les personnes qui peuvent ne pas être légalement capables de donner leur consentement. Toutefois, la capacité mentale décisionnelle des personnes ayant une maladie mentale peut exister à des niveaux différents et à des degrés divers et peut fluctuer au fil du temps. Dans la législation, il n'y a pas de degrés de capacité ou d'incapacité. Dans son mémoire adressé au Comité, l'Institut canadien catholique de bioéthique a expliqué :

> *Le système juridique tend à faire une distinction très nette entre les individus jugés «capables» de prendre des décisions concernant leur propre santé et ceux qui en sont incapables. Beaucoup d'individus atteints de maladies mentales comme la dépression profonde ou la schizophrénie pourraient ne pas répondre aux critères juridiques permettant de les déclarer «incapables» et, pourtant, leur capacité de comprendre leur propre état, d'évaluer leurs possibilités, de prendre des décisions judicieuses à propos de soins à recevoir et de s'en tenir à ces décisions peut être gravement compromise.*[530]

La capacité de donner son consentement est une condition essentielle pour la recherche impliquant des sujets humains. Mais l'évaluation clinique de la capacité mentale des personnes souffrant de maladie mentale ou de toxicomanie est un sujet très complexe et les essais cliniques applicables pour évaluer la compétence sont controversés. La maladie peut affecter la capacité de saisir et d'évaluer convenablement les risques et les avantages de

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528 Conseil de recherches médicales du Canada, Conseil de recherches en sciences naturelles et en génie et Conseil de recherches en sciences humaines. (1998) Énoncé de politique des trois Conseils : Éthique de la recherche avec des êtres humains, Article 1.

529 *Ibid.*, Article 2.

530 Institut canadien catholique de bioéthique. (20 février 2004) Mémoire présenté au Comité sénatorial permanent des affaires sociales, des sciences et de la technologie, p. 5.

participer à la recherche, ou les étapes nécessaires pour mettre en œuvre le plan de recherche. En outre, étant donné leur vulnérabilité, les personnes ayant une maladie mentale peuvent se sentir obligées de participer.

Le Comité comprend que la recherche sur la maladie mentale et la toxicomanie peut parfois être effectuée uniquement sur des personnes ayant une maladie qui altère leur capacité à donner leur consentement. Cependant, le Comité est préoccupé parce que l'orientation actuelle de la recherche impliquant des sujets humains envisage seulement la dichotomie du consentement donné librement ou les individus qui ne sont pas légalement habiles à donner leur consentement.

Il faut faire d'autres études pour élaborer de meilleures balises et des protections spéciales sur le traitement éthique des personnes atteintes de maladie mentale ou de toxicomanie comme sujets de recherche.

Les vulnérabilités et les circonstances uniques entourant la maladie mentale et la toxicomanie méritent que l'on se penche de près sur la conception éthique, l'examen et la conduite de la recherche. Une possibilité consiste, pour les gens atteints d'une maladie mentale, à avoir un porte-parole pour les aider au niveau des processus de participation à des recherches.

Les Instituts de recherche en santé du Canada ont entrepris des études sur l'éthique de recherche, notamment l'utilisation secondaire de renseignements personnels dans les recherches sur la santé et l'utilisation appropriée de placebos dans les essais cliniques.[531] Cependant, les membres du Comité estiment qu'il faut faire d'autres études pour élaborer de meilleures balises et des protections spéciales sur le traitement éthique des personnes atteintes de maladie mentale ou de toxicomanie comme sujets de recherche. Le Groupe consultatif interagences en éthique de la recherche, composé d'experts des trois organismes subventionnaires fédéraux, est chargé de surveiller l'élaboration et l'évolution de l'ÉPTC. En conséquence, le Comité recommande :

63	**Que le Groupe consultatif interagences en éthique de la recherche effectue une étude impliquant de vastes consultations pour savoir si l'Énoncé de politique des trois Conseils sur l'éthique de la recherche avec des êtres humains offre des protections adéquates et une orientation suffisante pour les recherches impliquant des personnes ayant une maladie mentale ou une toxicomanie. Le groupe devrait également explorer la possibilité d'utiliser les porte-parole des patients dans le cas de personnes atteintes de maladie mentale qui participent à des recherches.**

[531] Consultez le site web des Instituts de recherche en santé du Canada à l'adresse www.cihr-irsc.gc.ca.

Le concept de télésanté mentale (télémédecine et télépsychiatrie) a été mentionné fréquemment durant les audiences du Comité. Le terme plus général de télésanté désigne les soins de santé et autres services offerts par diverses technologies de l'information et des communications (TIC). La télésanté mentale désigne les services qui sont dispensés à distance par le biais des TIC pour les soins de santé mentale.

La télésanté mentale désigne les services qui sont dispensés à distance par le biais des technologies de l'information et des communications pour les soins de santé mentale.

La télésanté ne se limite pas aux applications des soins cliniques. Elle englobe également l'application des TIC à la formation normale et continue. On peut utiliser la technologie de la télésanté à diverses fins dont le diagnostic, le traitement, la formation, l'éducation et la consultation.

La première comprend les dossiers de santé, les bases de données et les registres électroniques, qui sont tous des exemples d'applications «en mode différé» impliquant des données stockées à un endroit et envoyées à un autre endroit à des fins d'utilisation. La deuxième est la télévision interactive bidirectionnelle (IATV), qui est la communication audio-visuelle entre au moins deux sites.

On peut classer le spectre des applications dans deux catégories principales. La première comprend les dossiers de santé, les bases de données et les registres électroniques, qui sont tous des exemples d'applications «en mode différé» impliquant des données stockées à un endroit et envoyées à un autre endroit à des fins d'utilisation. La deuxième est la télévision interactive bidirectionnelle (IATV), qui est la communication audio-visuelle entre au moins deux sites. Elle est également connue sous le nom de communication en temps réel, signal direct ou, plus couramment, vidéoconférence.

Les membres du Comité ont été informés que ces technologies présentent un potentiel considérable dans le domaine de la santé mentale. Le D[r] Ted Callanan, président de la Psychiatric Association of Newfoundland and Labrador, a déclaré devant le Comité que :

> *Comparativement à toutes les autres spécialités médicales, la psychiatrie peut offrir la gamme la plus vaste de services d'une manière efficiente et adéquate par le biais de la télétechnologie.*[532]

[532] 15 juin 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/22evb-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

12.1 PROGRAMMES ACTUELS

Inforoute comptait 21 projets de télésanté approuvés en cours et en avait achevés 14 autres — soit un total de 35 projets représentant des investissements estimés à plus de 6 millions de dollars.

À l'échelle nationale, l'Inforoute Santé du Canada (ISC) a été mise sur pied comme initiative stratégique des gouvernements fédéral, provinciaux et territoriaux pour jouer le rôle de chef de file en vue d'élaborer une capacité pour la gestion pancanadienne de l'information sur la santé et pour réaliser une meilleure coordination du large éventail en évolution constante des renseignements sur la santé et des initiatives technologiques. L'ISC a pour mission de favoriser et accélérer, à l'échelle pancanadienne, l'élaboration et l'adoption de systèmes d'information électroniques sur la santé, de normes et de technologies de communication compatibles. Elle mise sur les initiatives existantes et sur des partenariats de collaboration avec tous les intervenants concernés afin de procurer des avantages tangibles à tous les Canadiens.

Il faut davantage de ressources pour que les programmes de télésanté puissent atteindre leur plein potentiel.

Les dossiers de santé électroniques constituent à l'heure actuelle la principale priorité de l'ISC, cinq des six programmes d'investissement étant centrés sur cet objectif. Le sixième programme, la télésanté, a été ajouté au mandat de l'ISC en 2003. Les programmes locaux, régionaux et provinciaux peuvent maintenant faire une demande de financement à l'ISC pour leurs initiatives en matière de télésanté. L'information obtenue auprès d'ISC par le Comité a révélé que, au moment de rédiger le présent rapport, Inforoute comptait 21 projets de télésanté approuvés en cours et en avait achevés 14 autres — soit un total de 35 projets représentant des investissements estimés à plus de 6 millions de dollars. Inforoute les considère comme l'assise d'autres investissements futurs.[533]

La télésanté mentale est l'un des services de télésanté les plus fréquemment utilisés parce que le processus de diagnostic psychiatrique n'est pas principalement un processus physique mais repose plutôt sur la conversation verbale et non verbale.

Le nombre de programmes de télésanté et de projets pilotes locaux et régionaux a augmenté considérablement au cours de la dernière décennie. Néanmoins, un thème commun exprimé par les témoins précise qu'il faut davantage de ressources pour que les programmes de télésanté puissent atteindre leur plein potentiel. Certains témoins ont fait remarquer que même si de tels programmes seraient avantageux pour le bien-être des Canadiens dans l'ensemble du pays, l'approche adoptée jusqu'à présent a été trop localisée et les initiatives de télésanté ont généralement été sous-financées ou ont fait face à de trop nombreux obstacles réglementaires ou bureaucratiques pour être vraiment utiles au niveau des patients individuels et des prestateurs de services.

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533 Alvarez, R., président et chef de la direction, ISC. (7 novembre 2005) Lettre au Comité sénatorial permanent des affaires sociales, des sciences et de la technologie.

Cependant, d'autres témoins, comme la Dre Martha Donnelly, chef de la Division de la gériatrie communautaire au Vancouver General Hospital, ont mentionné que certains de ces problèmes sont en voie d'être résolus :

> *Par le passé, il y avait des obstacles au financement, mais aujourd'hui, on commence à les surmonter. Il pourrait y avoir des considérations médicales et juridiques… La mise en place des points d'accès pose également problème. La télésanté n'est pas gratuite… Cependant, je crois qu'on peut surmonter ces difficultés.*[534]

En fait, un rapport de Santé Canada, publié en octobre 2004 sous le titre *Télésanté mentale au Canada : Rapport sur la situation actuelle*, renforce les témoignages entendus par les membres du Comité à propos des progrès lents mais sûrs réalisés pour surmonter certaines de ces difficultés. Selon le rapport, la télésanté mentale est l'un des services de télésanté les plus fréquemment utilisés parce que le processus de diagnostic psychiatrique n'est pas principalement un processus physique mais repose plutôt sur la conversation verbale et non verbale. De fait, le rapport mentionne que «toutes les provinces et tous les territoires ont en effet tenté diverses expériences en matière de télésanté mentale, et certains en sont déjà à la phase de la mise en œuvre des programmes.»[535]

Cependant, le rapport mentionne également bon nombre des mêmes obstacles que les témoins ont porté à l'attention des membres du Comité, y compris les lacunes que présentent les infrastructures de télécommunications actuelles au pays, de même que les pénuries et la sous-formation des ressources humaines. Il fait remarquer que les politiques, dans des domaines comme la prestation des soins de santé, la rémunération et l'autorisation d'exercer, conçues pour les soins dispensés en personne, devront être modifiées si on veut les adapter aux exigences des télésoins.

Le rapport de Santé Canada énonce les sept «leçons retenues» qu'il faut prendre en considération si le Canada veut faire avancer de façon efficace son programme de télésanté mentale.

1. Une planification minutieuse est essentielle au succès des services de télésanté et de télésanté mentale.

2. La mise en pratique se fait toujours de façon graduelle, et un projet peut prendre plusieurs années pour réaliser son plein potentiel.

3. Le processus d'évaluation devrait être intégré à tout programme ou à toute initiative de télésanté mentale, en plus d'être adéquatement financé.

4. En dépit du peu de données disponibles au sujet de sa rentabilité, il semble que la télésanté permette de réaliser des économies d'échelle.

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534 8 juin 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/20ev-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

535 Santé Canada. (2004) *Télésanté mentale au Canada : Rapport sur la situation actuelle*, p. iii. Disponible en ligne à l'adresse www.hc-sc.gc.ca/hcs-sss/pubs/esanté-esante/2004-tele-mental/index_f.html.

5. Il a été démontré que la télésanté mentale procure des avantages tant aux clients qu'aux dispensateurs de soins, mais les patients semblent se laisser convaincre plus facilement que les dispensateurs.

6. La télésanté mentale propose un moyen de pallier les pénuries de professionnels de la santé mentale, mais ces mêmes pénuries risquent également de freiner sa croissance.

7. Une stratégie de gestion du changement exhaustive à volets multiples est essentielle à la réussite des initiatives de télésanté mentale.[536]

Les avantages et les défis de la télésanté mentale font l'objet d'une discussion plus détaillée ci-après.

12.2 AVANTAGES DE LA TÉLÉSANTÉ MENTALE

12.2.1 Accès aux soins

La télésanté mentale pourrait permettre aux gens d'obtenir un diagnostic et des soins dans leurs collectivités.

La télésanté mentale offre l'avantage supplémentaire de contribuer à aborder les questions relatives au stigmate associé aux services de soins de santé mentale.

L'avantage le plus fréquemment cité au niveau du déploiement plus systématique de la télésanté mentale (et de tous les services de télésanté) est sa capacité à accroître l'accès aux services de santé mentale et autres dans les collectivités rurales et éloignées. La plupart des spécialistes de la santé mentale se trouvent dans les centres urbains et aux alentours; les résidents des collectivités rurales et éloignées doivent se rendre dans ces centres pour les opérations de diagnostic et de traitement, phénomène appelé par certains témoins la «thérapie Greyhound». Le coût financier considérable et les dépenses en temps et en efforts que cela implique peuvent décourager des personnes de chercher à obtenir les soins dont ils ont besoin. Par ailleurs, la télésanté mentale pourrait permettre aux gens d'obtenir un diagnostic et des soins dans leurs collectivités. Les dispensateurs de soins de santé en milieu rural auraient également accès à des psychiatres et à d'autres prestateurs de services de santé mentale dans les centres urbains et pourraient aussi consulter d'autres spécialistes par le biais des TIC.

En fournissant des services d'humble profil aux utilisateurs, la télésanté mentale offre l'avantage supplémentaire de contribuer à aborder les questions relatives au stigmate associé aux services de soins de santé mentale. De nombreuses personnes sont découragées à l'idée de rechercher l'aide dont elles ont besoin par crainte que quelqu'un apprenne qu'elles consultent un spécialiste de la santé mentale. L'accès à la télésanté mentale par le biais d'un médecin de famille fiable ou d'un autre prestateur de soins de santé primaires permettrait donc à certains résidents ruraux d'obtenir des services de soins de santé mentale qu'ils pourraient autrement avoir refusé de demander.

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536 *Ibid.*, p. iv.

Par exemple, au Nouveau-Brunswick, la régie régionale de la santé 2 a branché des terminaux de télésanté mentale dans les salles d'urgence de petites villes avec les psychiatres du Saint. John Regional Hospital qui sont en fonction 24 heures sur 24. Cette mesure a non seulement amélioré l'accès mais elle a également atténué les problèmes associés au stigmate parce que les patients n'ont plus besoin de se déplacer pour recevoir des soins. Krisan Palmer, infirmière autorisée et coordonnatrice des initiatives de télésanté de la région, a déclaré au *Medical Post* que les services de télésanté mentale ont «vraiment contribué à établir la confidentialité des patients.»[537] Cette initiative régionale est déployée à l'échelle de la province.

12.2.2 Améliorer le recrutement et la rétention dans les collectivités rurales

La télésanté a également le potentiel de contribuer à atténuer la pénurie de professionnels de la santé dans les régions rurales et éloignées.

La télésanté a également le potentiel de contribuer à atténuer la pénurie de professionnels de la santé dans les régions rurales et éloignées. La concentration actuelle de psychiatres et d'autres spécialistes dans les régions urbaines a peu de chances de changer dans un avenir rapproché. Toutefois, le recours aux TIC pourrait servir d'incitatif pour attirer et retenir des professionnels de la santé dans des régions rurales et éloignées du Canada. La télésanté mentale peut à la fois contribuer à fournir le soutien clinique nécessaire et favoriser les liens entre les professionnels de la santé dans les régions éloignées et leurs pairs en milieu urbain.

En utilisant la technologie, comme les vidéoconférences, les médecins et les spécialistes peuvent améliorer leur formation et renforcer leurs connaissances en se consultant mutuellement et en participant à des conférences.

Les régions rurales demeurent peu attrayantes pour de nombreux médecins et spécialistes en raison de l'isolement professionnel auquel ils font face. De nombreux praticiens sont opposés à l'interaction réduite avec leurs pairs du milieu médical, qui est un fait des milieux de travail en zones rurales et éloignées, et à l'obligation de mener leur pratique largement de leur propre initiative. La télésanté peut contribuer à redresser cette situation en donnant à ces praticiens l'accès à d'autres prestateurs de soins de santé, y compris à des professionnels de la santé mentale.

De nombreux praticiens s'inquiètent également du fait que les régions rurales offrent moins de possibilités de formation médicale continue. Ils doivent venir de loin pour assister à des conférences ou pour avoir accès à d'autres soutiens éducatifs. La télésanté mentale contribue à satisfaire ce besoin. À cet égard, Sharon Steinhauer, membre de l'Alberta Mental Health Board, a fait remarquer que les «médecins de famille… peuvent ainsi non seulement accéder immédiatement à un psychiatre et à des services psychiatriques de soutien ou autre, mais à une formation permanente dans ces domaines par le biais de sessions de télésanté mentale.»[538] En utilisant la technologie, comme les vidéoconférences, les médecins et les

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537 Sylvain, M. (15 novembre 2005) Telemental health service reaches out to remote N.B. *Medical Post*, Volume 41, Numéro 49.

538 9 juin 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/21eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

spécialistes peuvent améliorer leur formation et renforcer leurs connaissances en se consultant mutuellement et en participant à des conférences.

12.2.3 Soins en collaboration

Tel que mentionné précédemment dans le présent rapport, de nombreuses régies régionales de la santé encouragent la création d'équipes multidisciplinaires dans la prestation des soins de santé. Les modèles de soins en collaboration pour la prestation des soins de santé mentale sont également de plus en plus répandus.[539] La télésanté mentale facilite le modèle des soins en collaboration et la coopération entre les médecins de famille et les psychiatres.

Même s'il subsiste encore des obstacles à surmonter (dont les problèmes de financement et de rémunération décrits ci-après), la télésanté offre un moyen de mettre en pratique un modèle de collaboration pour la santé mentale par le biais de consultations vidéo, de conférences de cas et de séances éducatives, de ressources de formation par Internet et de programmes de formation médicale continue.

La télésanté offre un moyen de mettre en pratique un modèle de collaboration pour la santé mentale.

En outre, le rapport de Santé Canada sur la télésanté mentale mentionne qu'il est important de chercher des moyens d'intégrer la télésanté mentale dans l'objectif plus vaste de la réforme des soins primaires, en suggérant que :

> …les applications de télésanté mentale soient élaborées et mises en œuvre non pas en vase clos, mais en tant que partie intégrante du continuum des soins. Ainsi, la télésanté mentale pourrait tenir lieu de catalyseur pour d'éventuelles réformes, en particulier dans le cas des soins primaires, aux dires des informateurs clés provenant de différents provinces et territoires.

12.2.4 Collectivités autochtones

Une fois que la télésanté mentale sera convenablement financée et implantée, elle pourrait contribuer à fournir le niveau de service dont tant de collectivités ont si désespérément besoin.

Pour de nombreuses Premières nations et collectivités inuit, il est extrêmement important que les services de télésanté mentale aient le potentiel d'améliorer l'accès aux soins dans les régions rurales et éloignées. L'accès aux soins psychiatriques est limité dans les collectivités autochtones les plus septentrionales; la majorité n'en ont actuellement aucun et, dans les autres, la pénurie est marquée.[540] Souvent, les collectivités partagent un seul professionnel de la santé qui se déplace de l'une à l'autre et que les clients doivent aller voir pour obtenir des soins. Des professionnels de la santé mentale et d'autres spécialistes ne sont généralement disponibles que très loin et les frais de déplacement associés peuvent être très élevés. Ian Potter, sous-ministre adjoint, Direction de la santé des Premières nations et des Inuits, Santé Canada, a déclaré aux membres du Comité :

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539 Voir le Chapitre 5 pour une discussion plus détaillée portant sur les soins en collaboration.

540 Voir le Chapitre 14 pour une discussion plus détaillée sur les défis énormes auxquels font face les collectivités autochtones pour améliorer le bien-être mental de leurs habitants.

> *Nous obtenons présentement de bons résultats dans un aspect prometteur… Il s'agit des services de télésanté mentale, qui permettent aux patients de demeurer dans la communauté où ils peuvent communiquer avec d'autres. Ainsi, grâce à un système de vidéoconférence, nous pouvons leur offrir les services psychiatriques d'établissements lointains pendant qu'ils demeurent auprès de leur famille.*[541]

Une fois que la télésanté mentale sera convenablement financée et implantée, elle pourrait contribuer à fournir le niveau de service dont tant de collectivités ont si désespérément besoin.

12.3 DÉFIS

12.3.1 Questions de compétences: autorisation d'exercer et rémunération

La plupart des provinces doivent encore se pencher sérieusement sur les questions relatives aux politiques de rémunération spécifiques à leurs secteurs de compétence.

L'une des caractéristiques les plus attrayantes de la télésanté mentale — sa capacité d'offrir des services à de grandes distances — présente également l'un des principaux défis. La pratique de la médecine est une responsabilité provinciale/territoriale; les praticiens sont autorisés à exercer dans chaque province ou territoire. Un avantage clé des activités de la télésanté résulte du fait qu'elle permet la collaboration entre les professionnels de la santé mentale de plusieurs secteurs de compétence. Cependant, la réglementation et le financement de cette pratique exigent des accords d'autorisation entre les divers secteurs de compétence dans lesquels les professionnels de la santé qui participent à la télésanté mentale, ou à la télésanté en général, se trouvent et sont autorisés à exercer.

Même si certains secteurs de compétence ont des accords d'autorisation pour la pratique transfrontière, ce n'est pas le cas pour la plupart. Les accords d'autorisation entre l'Île-du-Prince-Édouard et la Nouvelle-Écosse autorisent le partage de certains services de télépsychiatrie, mais des accords comparables n'existent pas dans la plupart des autres régions du Canada. Leur absence peut faire hésiter les professionnels de la santé à participer à des initiatives en matière de télésanté mentale.

De même, l'élaboration des bonnes politiques de rémunération représente un autre défi à relever si on veut élargir les services de télésanté. Même si l'autorisation d'exercer relève du Collège des médecins et chirurgiens de chaque province ou territoire, les gouvernements provinciaux et territoriaux doivent eux-mêmes se demander si les services de télésanté mentale seront assurés et financés à partir des régimes de santé publics.

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[541] 20 avril 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/13eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

Le rapport de Santé Canada affirme que la plupart des provinces doivent encore se pencher sérieusement sur les questions relatives aux politiques de rémunération spécifiques à leurs secteurs de compétence :

> La plupart des provinces et des territoires disposent maintenant de politiques de rémunération des médecins pour les services de télésanté (y compris de télésanté mentale), mais on considère généralement que celles-ci ne réussissent pas à inciter les dispensateurs à se tourner vers la télésanté mentale. En Alberta par exemple, comme l'ont souligné les informateurs clés, les médecins touchent les mêmes honoraires pour une séance de télésanté que pour une consultation en personne. Par contre, le tarif des honoraires de la Saskatchewan tient compte des problèmes d'ordre technique que peuvent rencontrer les médecins. Or, aux dires des informateurs clés, une séance de télésanté dure en réalité plus longtemps qu'une consultation en personne. À Terre-Neuve, la pédopsychiatrie est le seul service de télésanté mentale qui prévoit une rémunération à l'acte, tandis qu'au Manitoba, la grille des honoraires ne fait aucune mention des conférences de cas. Au Québec, la loi précise clairement que la télésanté ne constitue pas un service assuré. En Colombie-Britannique et en Ontario, aucune disposition de rémunération à l'acte n'a été mise en place en ce qui a trait aux vidéo-conférences de consultation entre patients et dispensateurs. De manière à recruter des professionnels, les gestionnaires de programmes et de projets ont donc tenté d'atténuer l'effet de ces politiques inadéquates de rémunération à l'acte en ayant recours à des ententes contractuelles, en faisant appel à des médecins salariés et en réglant les coûts des séances à même les fonds affectés aux programmes et aux projets.[542]

En conséquence, le Comité recommande :

64	**Que les provinces et territoires collaborent pour mettre en œuvre des accords d'autorisation et des politiques de rémunération qui permettront de développer les initiatives de télésanté mentale partout au pays.** **Que la Commission canadienne de la santé mentale (voir le Chapitre 16) collabore avec les provinces et les territoires en vue d'identifier et de résoudre tous les problèmes d'autorisation d'exercer et de rémunération qui sont en suspens.**

542 Santé Canada. (2004) Télésanté mentale au Canada : Rapport sur la situation actuelle, p. 11.

12.3.2 Financement

Les activités de télésanté mentale ont débuté comme des projets temporaires ou pilotes et ont évolué vers des programmes financés à long terme. Même si certains ont obtenu le financement nécessaire pour maintenir leur niveau de fonctionnement actuel, dans bien des cas le financement est insuffisant pour les étoffer ou pour créer de nouveaux projets. Les frais de démarrage pour un site de télésanté mentale englobent le matériel de vidéoconférence, qui peut coûter jusqu'à 100 000 $ par système, tandis que la communication entre les sites exige des fonds supplémentaires pour la connexion par Internet, par réseau intégré de services (RIS) ou par satellite.

Il est important que le gouvernement fédéral contribue au déploiement d'initiatives de télésanté mentale à travers le pays.

Même si le gouvernement fédéral a accordé une aide financière pour le développement de services de télésanté mentale, il ne met pas en œuvre et ne maintient pas directement ces services de santé ou d'autres, à l'exception notoire des services de santé accordés aux populations envers lesquelles le gouvernement fédéral a une responsabilité (les Premières nations et les Inuit, les anciens combattants, les détenus fédéraux, les immigrants et les réfugiés, les militaires et la Gendarmerie Royale du Canada). Pour cette raison, les services de télépsychiatrie sont généralement administrés par les gouvernements provinciaux/territoriaux, les établissements universitaires, les régies régionales de la santé ou les hôpitaux, ou par une combinaison de ces divers intervenants.

Le financement et la durabilité posent un problème important pour de nombreux programmes, en particulier dans le Nord où les frais de télécommunications sont très élevés à cause d'une plus grande dépendance vis-à-vis des branchements coûteux établis par satellite. La fin d'un certain nombre d'initiatives de Santé Canada a empêché l'expansion des programmes de télésanté mentale. Parmi les initiatives se rapportant à la télésanté mentale qui sont maintenant abolies, citons le Programme des partenariats pour l'infostructure canadienne de la santé (PPICS), le Programme de soutien à l'infostructure de la santé (PSIS), le Fonds pour l'adaptation des services de santé (PASS), l'Initiative de développement et d'échange des connaissances (DEC) et l'Initiative pour la recherche appliquée. Bon nombre de programmes provinciaux/territoriaux existants, qui continuent de fonctionner, ont été amorcés dans le cadre de ces programmes.

Tel que mentionné précédemment, l'Inforoute Santé du Canada a été créée pour aider à appuyer notamment l'élaboration de programmes de télésanté. Cependant, le financement de l'ISC ne couvre pas les frais d'exploitation, l'infrastructure de réseautage, ni l'entretien et l'amélioration du matériel, des logiciels et des serveurs. Le financement de tels services de télésanté mentale provient en grande partie des gouvernements provinciaux et territoriaux.

Selon le rapport de Santé Canada déjà mentionné, tous les gouvernements financent certains services de télésanté mentale, mais à des degrés nettement différents. Dans certains secteurs de compétence, l'incertitude du financement constitue un obstacle important à l'expansion des services de télésanté mentale. Ian Shortall, chef de division, Programme Bridges, Health Care Corporation of St. John's, a déclaré aux membres du Comité que «il faut recourir

davantage à la technologie, à la télépsychiatrie… mais le financement a manqué pour poursuivre l'expérience.»[543]

Les membres du Comité sont d'avis qu'il est important que le gouvernement fédéral contribue au déploiement d'initiatives de télésanté mentale à travers le pays. À cet égard, le Comité prend note de l'annonce faite le 13 octobre 2005, à l'effet que le gouvernement du Canada a investi 4,62 millions de dollars visant à faire progresser la technologie du service à large bande qui permettra d'améliorer les soins de santé et les services de protection civile offerts en région rurale.[544]

Le fait d'étendre le même ratio de financement que les autres programmes au programme de télésanté contribuerait à accélérer les investissements et à faire progresser la télésanté.

Avec le temps, et une fois que les infrastructures seront en place, il devrait être possible pour les provinces et les territoires d'utiliser les économies découlant des frais réduits de transport et autres, qui seront réalisées en implantant les services de télésanté mentale, pour financer les coûts d'exploitation de ces services. Entre-temps, dans le but d'aider à faire la transition vers cette «situation stable», le Comité recommande :

65	**Que les initiatives de télésanté mentale soient admissibles à un financement par le biais du Fonds pour l'adaptation des services de santé mentale (voir le Chapitre 16).**

En outre, Richard Alvarez, président et chef de la direction de l'Inforoute Santé du Canada, a informé les membres du Comité d'une restriction dans son accord de financement avec le gouvernement fédéral à propos de la télésanté : l'ISC ne peut couvrir que jusqu'à 50 p. 100 des coûts admissibles des projets de télésanté.[545] Cette contrainte ne s'applique pas aux autres programmes de l'ISC, dans lesquels le ratio de financement moyen atteint maintenant un ratio de 75(Inforoute):25(parrain). Le Comité est d'accord avec M. Alvarez que le fait d'étendre le même ratio de financement que les autres programmes au programme de télésanté contribuerait à accélérer les investissements et à faire progresser la télésanté au Canada. Par conséquent, le Comité recommande :

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543 14 juin 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/22eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

544 Industrie Canada (13 octobre 2005). Communiqué disponible en ligne à l'adresse http://www.ic.gc.ca/cmb/welcomeic.nsf/d2ba51d479ae569a852564ca0064238a/85256a5d006b97208525709900678c59!OpenDocument}.

545 Alvarez, R., président et chef de la direction, ISC. (7 novembre 2005) Lettre au Comité sénatorial permanent des affaires sociales, des sciences et de la technologie.

66	**Que l'accord de financement entre l'Inforoute Santé du Canada et le gouvernement du Canada soit révisé de telle sorte que l'Inforoute Santé du Canada ne soit plus obligée de ne couvrir qu'un maximum de 50 % des coûts admissibles des projets de télésanté et puisse fixer, pour ses investissements dans les projets de télésanté, le même ratio que dans les autres projets.**

12.3.3 Évaluation

Avant qu'un service de santé puisse être adopté comme une pratique normalisée, il doit tout d'abord faire l'objet d'une évaluation approfondie. Un obstacle important à la mise en œuvre de nouveaux programmes de télésanté mentale est l'absence de modalités d'évaluation normalisées. Puisqu'il n'existe pas de normes nationales permettant d'évaluer les projets de télésanté mentale, les études qui évaluent l'efficacité de tels projets n'utilisent pas des ensembles d'indicateurs communs et ne peuvent pas faire l'objet de comparaisons mutuelles fiables. Sans preuves cohérentes et fiables concernant la télésanté mentale comme méthode efficace de prestation de soins, les régies de la santé et les ministères provinciaux/territoriaux de la Santé sont peu enclins, et c'est compréhensible, à financer de nouveaux projets.

En conséquence, le Comité recommande :

67	**Que le Centre d'échange des connaissances (voir le Chapitre 16) collabore avec les provinces et les territoires, ainsi qu'avec d'autres organismes comme l'Institut canadien d'information sur la santé, dans le but de mesurer la rentabilité de la prestation des soins de télésanté mentale comparativement aux modes de prestation traditionnels.** **Que le Centre d'échange des connaissances contribue au développement d'outils d'évaluation pour les services de télésanté mentale.**

12.3.4 Ressources humaines

La pénurie de professionnels de la santé mentale dans de nombreuses régions du Canada limite gravement le développement et la mise en œuvre de services de télésanté mentale. Tel que mentionné précédemment, la télésanté mentale peut avoir une influence positive en vue d'attirer et de retenir des prestateurs de soins de santé dans les régions rurales et éloignées. Cependant, il peut s'avérer difficile de mettre sur pied et de faire fonctionner des services de télésanté mentale, surtout lorsque la concurrence est âpre pour l'utilisation des ressources humaines plutôt rares. Tel que mentionné dans le rapport de Santé Canada : «La télésanté mentale propose un moyen de pallier les pénuries de professionnels de la santé mentale, mais ces mêmes pénuries risquent également de freiner sa croissance.»

La prestation de services de santé mentale par télécommunications semble une option très prometteuse, mais elle est encore nouvelle. De nombreux prestateurs de soins de santé mentale ne sont toujours pas familiers avec la télésanté mentale, sont sceptiques quant à son utilité et, de fait, ne se sentent pas capables de l'utiliser efficacement. Même si certains prestateurs s'efforcent activement, à l'heure actuelle, d'adapter leurs ensembles de compétences en vue de dispenser des soins par la télésanté, d'autres résistent à la conversion.

En conséquence, le Comité recommande :

68	**Que la Commission canadienne de la santé mentale (voir le Chapitre 16) encourage l'inclusion de cours en télésanté mentale dans les écoles de médecine et qu'elle collabore avec les provinces et les territoires, ainsi qu'avec les organismes professionnels concernés, pour offrir aux actuels fournisseurs de soins de santé de l'information sur la télésanté mentale par le biais de son Centre d'échange des connaissances.**

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SENATE OF CANADA

Proceedings of the Standing Senate Committee on

Social Affairs, Science and Technology

Chair:
The Honourable MICHAEL KIRBY

Monday, May 8, 2006

Issue No. 2
Volume 4 of 5

SECOND REPORT OF THE COMMITTEE
(Final report on mental health, mental illness and addiction entitled:
OUT OF THE SHADOWS AT LAST
Transforming Mental Health, Mental Illness and Addiction Services in Canada — Part V)

Première session de la
trente-neuvième législature, 2006

SÉNAT DU CANADA

Délibérations du Comité sénatorial permanent des

Affaires sociales, des sciences et de la technologie

Président :
L'honorable MICHAEL KIRBY

Le lundi 8 mai 2006

Fascicule n° 2
Volume 4 de 5

DEUXIÈME RAPPORT DU COMITÉ
(Rapport final sur la santé mentale, la maladie mentale et la toxicomanie intitulé :
DE L'OMBRE À LA LUMIÈRE
La transformation des services concernant la santé mentale, la maladie mentale et la toxicomanie au Canada — partie V)

44058

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ON SOCIAL AFFAIRS, SCIENCE
AND TECHNOLOGY

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Published by the Senate of Canada

Available from: Public Works and Government Services Canada
Publishing and Depository Services, Ottawa, Ontario K1A 0S5

Also available on the Internet: http://www.parl.gc.ca

Publié par le Sénat du Canada

Disponible auprès des: Travaux publics et Services gouvernementaux Canada –
Les Éditions et Services de dépôt, Ottawa (Ontario) K1A 0S5

Aussi disponible sur internet: http://www.parl.gc.ca

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PART V

Federal Leadership

CHAPTER 13:
THE FEDERAL DIRECT ROLE

> *...initiate and coordinate activity across all federal departments to address federal government responsibilities to specific populations under its direct jurisdiction. —Dr. Albert Schumacher, President, Canadian Medical Association*[1]

The federal government has significant responsibility for programs and services related to the mental health of seven client groups. For each group, this chapter provides an extensive description of the source of the federal authority and the array of federal programs and services for mental health, mental illness and addiction that are in place. It then offers some assessment of the needs of each group and a commentary about each situation.

To the best of the Committee's knowledge, this is the first time a comprehensive look at the mental health needs of all the federal client groups has been undertaken. Therefore, following its examination of each client group, the Committee reviews the broader implications of the federal government's addressing the mental health concerns of the more than one million Canadians who are its clients. In this chapter's concluding section, the Committee identifies components of an integrated approach to improving mental health outcomes for all federal client groups.

To facilitate reading this long chapter, the following table provides a brief snapshot of the contents of each section pertaining to specific client groups. It presents a summary overview identifying the particular client groups, the responsible federal departments, and the general mental health activities undertaken by them.

Table 1: Federal Client Groups in Summary

Client Groups	Federal Departments	General Mental Health Activities
First Nations and Inuit (13.1)	Health Canada	Community-based mental health care for First Nations on-reserve; Non-insured drugs and short-term mental health crisis counseling for registered First Nations and recognized Inuit; Addiction treatment centres.
	Indian and Northern Affairs Canada	Basic services for First Nations on-reserve and in Inuit communities including education, income assistance, housing, family violence prevention.

[1] 20 April, 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/13eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

Client Groups	Federal Departments	General Mental Health Activities
Federal Offenders (13.2)	Correctional Service Canada	Basic mental health nursing assessment at reception centres; admission to treatment centres if necessary and available; general services at regular institutions; essential services if in Community Correctional Centre; non-insured health care coverage if approved.
Canadian Forces (13.3)	National Defence	Non-emergency, outpatient mental health through base clinics, health care centres and support units; Specialized mental health services purchased from provinces; Referrals to operational trauma and stress support centres.
Veterans (13.4)	Veterans Affairs Canada	Community based mental health care services extending beyond provincial or territorial plans; Institutional mental health care in Ste-Anne-de- Bellevue, Quebec and in contract hospitals in provinces; Shared services with DND on operational trauma and stress.
RCMP (13.5)	RCMP	General health services offered within regional divisions to ensure fitness to perform duties; Use of provincial services as authorized.
Immigrants and Refugees (13.6)	Citizenship and Immigration Canada	Essential and emergency mental health services (physician, hospital, and drug) for those unable to pay.
Federal Public Service Employees (13.7)	Treasury Board	Coverage of services and other benefits not provided through provincial/territorial insurance plans; Employee assistance counseling.

From the outset, the Committee emphasizes that it expects the federal government, together with its provincial and territorial counterparts, to ensure that federal clients have access to the system transformations already identified in Chapter 5. Thus, the Committee intends First Nations and Inuit, federal offenders, Canadian Forces members, veterans, RCMP members, immigrants and refugees and federal public service employees to be part of a mental health system that is recovery-oriented, person-centred, community based, and integrated across the full continuum of care and all age groups.

The Committee is pleased with the significant evidence that individual federal departments and agencies have moved in this direction. Some departments have developed approaches that utilize case management and a wider range of mental health providers. Others have focused on mental health enhancements through improvements to the determinants of mental health such as housing, employment and broad social needs. Several departments and agencies are working collaboratively with one another and with their provincial and territorial counterparts on mental health initiatives.

13.1 FIRST NATIONS AND INUIT

> *Inuit have embraced the federal commitment to a renewed relationship and believe that a further commitment for an Inuit-specific mental health strategy is important. —Larry Gordon, Chairman, National Inuit Committee on Health, Health Department, Inuit Tapiriit Kanatami*[2]

> *A collaborative action plan and wellness strategy between federal and First Nations leadership would immediately address the mental wellness crisis in a manner that is collaborative, comprehensive and culturally relevant. —Valerie Gideon, Director of Health and Social Secretariat, Assembly of First Nations*[3]

13.1.1 Federal Responsibility

Under the *Constitution Act, 1867,* section 91(24) allocated exclusive legislative responsibility over "Indians and Lands reserved for the Indians" to the federal Parliament. In turn, Parliament passed the *Indian Act* of 1876 that established the criteria for a "status Indian" together with a framework for federal jurisdictional responsibilities. A ruling of the Supreme Court in 1939 further determined that Inuit (then called Eskimos) were Indians for the purposes of section 91(24).[4]

It is important to note that this section looks only at the First Nations and Inuit clients who are identified primarily as federal clients. The federal government does *not* acknowledge responsibility for all Aboriginal peoples; it is estimated that one-third of Aboriginal peoples do not have specific access to federal programs and services. At the present time, the federal government provides certain federal programs and services to status Indians (also known as Registered Indians and First Nations) that are not available to non-status Indians or to Métis. In addition, some but not all federal programs and services have been extended to Inuit.

This chapter considers only the First Nation and Inuit considered eligible for federal programs and services relevant to mental health, the main focus being on those delivered through the departments of Health Canada and Indian and Northern Affairs. The following chapter (Chapter 14) provides a broader perspective in that it covers the mental health of all Aboriginal peoples, including non-status (and off-reserve status Indians) as well as Métis. Chapter 14 also presents the components for a comprehensive, integrated, community-based

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2 21 April 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/13evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

3 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

4 *Indian Act*, R.S. 1985, c. I-5, http://laws.justice.gc.ca/en/I-5/, Tonina Simeone, *Federal-Provincial Jurisdiction and Aboriginal Peoples*, TIPS-88E, Library of Parliament, 2001.
Mary Hurley, *The Indian Act*, TIPS-17, Library of Parliament, 2004, http://lpintrabp.parl.gc.ca/apps/tips/printable/tip17-e.pdf.

wellness and healing strategy that supports distinct approaches for all groups of Aboriginal peoples.

Indian and Northern Affairs Canada has primary responsibility for the constitutional and statutory obligations and responsibilities of the federal government to Indian and Inuit people. Through the administration of the *Indian Act,* the department supports self-government, economic, educational, cultural, social, and community development for registered Indians and certain Inuit. According to the departmental performance report of 31 March 2005, the total Status Indian population was 733,626.[5] The report provides no indication of the size of the Inuit population.

Health Canada has primary federal responsibility for health services, including mental health services, to First Nations and Inuit on all reserves and in many remote and isolated communities; it delivers these services through nursing stations and health centres. In addition, the 2005 departmental performance report indicated that Health Canada provides "supplementary health benefits to approximately 765,000 eligible First Nations and Inuit people."[6]

Health Canada has primary federal responsibility for health services, including mental health services, to First Nations and Inuit on all reserves and in many remote and isolated communities; it delivers these services through nursing stations and health centres.

Ian Potter, Assistant Deputy Minister, First Nations and Inuit Health Branch, Health Canada described the agreement on Federal Indian Health Policy signed in 1979 that defines the current roles of the federal and provincial governments.[7]

The division of mental health responsibilities between the federal health department and its provincial or territorial counterparts is "often confusing, even for those of us who are in this on a day-to-day basis."

> *It meant that on isolated reserves and areas where provinces were not providing primary care, the federal government would continue to finance and provide that. It meant that the federal government would provide public health services on all reserves, including prevention services. As well, it meant that the federal government would provide non-insured drugs, dental work and transportation for all First Nations and Inuit on and off-reserve.*[8]

Mr. Potter acknowledged that the division of mental health responsibilities between the federal health department and its provincial or territorial counterparts is "often confusing, even for those of us who are in this on a day-to-day basis." He nonetheless offered the following capsule description:

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5 Indian Affairs and Northern Development Canada, *Performance Report for the period ending March 31, 2005*, p. 21, http://www.tbs-sct.gc.ca/rma/dpr1/04-05/INAC-AINC/INAC-AINCd45_e.pdf.

6 Health Canada, *Performance Report for the period ending March 31, 2005*, p. 6, http://www.tbs-sct.gc.ca/rma/dpr1/04-05/HLTH-SANT/HLTH-SANTd45_e.pdf.

7 Health Canada, *Federal Indian Health Policy 1979*, http://www.hc-sc.gc.ca/fnih-spni/services/indi_health-sante_poli_e.html.

8 20 April 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/13eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

Basic mental health services and addiction services are provided primarily by provincial governments to all residents of the province, which includes First Nation, Inuit and other Aboriginal people. They provide hospital care, psychiatric and general physician services. Provinces also provide community-based prevention, outpatient treatments, aftercare, detoxification services and residential addiction treatment services.[9]

13.1.2 Federal Programs and Services

Indian and Northern Affairs Canada and Health Canada have increasingly delegated to First Nations authorities and some Inuit communities their departmental responsibility for the administration and delivery of many programs and services vital for mental health. Specific eligibility criteria still apply to these programs regardless of who provides them:

Within the federal jurisdiction, Indian and Northern Affairs Canada has the widest scope of programs and services related to the broad determinants of mental health. It offers services to First Nations on reserves that are similar to those delivered by provinces to their general populations.

- Indians must be registered as an Indian under the *Indian Act* and be recorded on the Indian Register; Inuit have a recipient identification number.
- For some services, prior approval is required from departmental authorities.
- The programs serve eligible individuals resident or ordinarily resident on a reserve or in a recognized Inuit community.

Within the federal jurisdiction, Indian and Northern Affairs Canada has the widest scope of programs and services related to the broad determinants of mental health. It offers services to First Nations on reserves that are similar to those delivered by provinces to their general populations. These services include education, income assistance, and infrastructure support and account for more than 80 percent of total on-reserve funding.

Health Canada's First Nations and Inuit Health Branch estimated its annual spending on mental health, mental illness and addictions-related programs and services to be $267.5 million.

Indian and Northern Affairs Canada's Elementary/Secondary Education Program provides access to schools, either by funding instructional services on reserves, or by covering the cost of attending provincial or territorial schools. Its Social Assistance Program helps First Nations individuals and families living on reserves meet basic needs for food, clothing and shelter. Its Family Violence Prevention Program funds some shelters on-reserve, reimburses shelters located off-reserve for services provided to First Nations people who ordinarily live on a reserve and also funds community-based family violence prevention programs.

Health Canada's First Nations and Inuit Health Branch estimated its annual spending on mental health, mental illness and addictions-related programs and services to be

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[9] 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/13eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

$267.5 million. This included $36.4 million in 2004/2005 spent through the Non-Insured Health Benefits Program on pharmaceuticals to treat mental illness and addiction.[10]

The estimate also included community-based prevention and promotion programs on reserves and in Inuit communities:

> *... $40 million a year in ongoing funding to community-based mental health programs through a program called Building Healthy Communities, and an additional $51 million per year for mental health and child development activities through Brighter Futures.*

In addition, addiction programs were provided to First Nations and Inuit organizations through

> *... the National Native Alcohol and Drug Abuse Program ($59 million per year), the Youth Solvent Abuse Program ($11 million per year), the First Nations and Inuit Tobacco Control Strategy ($12 million per year), and the Canadian Drug Strategy ($1 million per year).*[11]

Mental health counselling, usually provided by psychologists, was available through the Non-Insured Health Benefits program to eligible First Nations and Inuit regardless of residency. Kathryn Langlois, Director General, Community Programs Directorate, First Nations and Inuit Health Branch, Health Canada, emphasized that federal provision was limited to short-term counselling:

> *We would provide the short-term crisis mental health counselling and then a referral would be made to the provincial system. It would be accessed in the same way as any individual off-reserve, through emergency or a family physician. The province would pay.*[12]

Kathryn Langlois also referred to substantial departmental work on suicide that was begun after a suicide prevention advisory group was set up in 2002 by then National Chief Matthew Coon Come and Health Minister Alan Rock. New funding announced in September 2004 included $65 million allocated over five years for an Aboriginal youth suicide prevention strategy; $5 million was allocated for 2005 and $15 million for each of the next four years.

Health Canada has also convened a First Nations and Inuit Mental Wellness Advisory Committee (MWAC) to develop a strategic action plan to improve mental wellness outcomes for First Nations and Inuit.

Health Canada has also convened a First Nations and Inuit Mental Wellness Advisory Committee (MWAC) to develop a strategic action plan to improve mental wellness

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10 Correspondence from Ian Potter, Assistant Deputy Minister, First Nations and Inuit Health Branch, Health Canada to Senator Michael Kirby, Chair, Standing Committee on Social Affairs, Science and Technology, The Senate, 7 September, 2005.

11 20 April 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/13eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

12 20 April 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/13eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

outcomes for First Nations and Inuit. The committee includes representatives from the Assembly of First Nations, Inuit Tapiriit Kanatami, Federal/Provincial/Territorial networks, mainstream and Aboriginal expert mental health and addictions organizations, Indian and Northern Affairs Canada, and the Public Health Agency of Canada. Following a strategic planning session with content experts in November 2005, a draft plan was made available for the committee's review in February 2006.[13]

13.1.3 Assessments of Client Group Needs

The registered Indians and recognized Inuit that make up the defined federal client group have a very diverse set of characteristics. For example, while the services and programs are available primarily for First Nations living on-reserve, many individuals migrate in and out regularly. Some Inuit live within the area covered by land claims agreements while others do not.

Overall, these clients have poor health status, "well below that of the rest of Canadians".

Overall, these clients have poor health status, "well below that of the rest of Canadians."[14] Furthermore, providing services to them is made more difficult due to their geographic dispersal across wide areas; many live in remote or isolated communities.

13.1.3.1 Indian and Northern Affairs Canada's Programs and Services

Indian and Northern Affairs Canada has responsibility for several key factors that are essential to a comprehensive approach to the mental health of First Nations and Inuit communities, factors such as economic development, housing and education. Witnesses told the Committee that the Department's efforts fell short of expectations. Irene Linklater, Research Director, Research and Policy Development Unit, Assembly of Manitoba Chiefs criticized the fact that:

> *... the Department of Indian Affairs spends 13 million on social assistance to every $1.00 in economic development. The impact has been that Manitoba First Nations communities have at least one-third to one-half of the First Nations on-reserve population on income assistance, with a range of 24 to 88% in some communities.*[15]

Witnesses also made a connection between serious housing inadequacies and the resulting negative effects on mental health:

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13 Correspondence from Ian Potter, Assistant Deputy Minister, First Nations and Inuit Health Branch, Health Canada to Senator Michael Kirby, Chair, Standing Committee on Social Affairs, Science and Technology, The Senate, 7 February 2006, p. 2.

14 Health Council of Canada, The Health Status of Canada's First Nations, Inuit and Métis, January 2005, http://healthcouncilcanada.ca.c9.previewyoursite.com/docs/papers/2005/BkgrdHealthyCdnsENG.pdf.

15 According to Linklater, the statistic was from research conducted by the Assembly of Manitoba Chief in 2001; 1 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/16evc-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

The experience of what is considered homelessness and what we see as invisible homelessness is that by living in such crowded conditions, there is a constant moving of people and houses, and they are not found within the statistics; in other words, you do not see that reflected within a statistical framework. Lack of proper housing is associated also — and research studies confirm this — with lack of personal care, ill health, and lower longevity. — Irene Linklater[16]

A federal housing program in the Arctic Inuit regions would not only resolve the housing shortages, but it would also alleviate some of the social problems such as family violence and addictions. — Larry Gordon[17]

Donna Lyon from the National Aboriginal Health Organization talked about limits on post-secondary education support, particularly the difficulties of accessing funding from departmental sources. She also suggested that, even when resources are available, they may be insufficient to sustain a student with a dependent family:

... you have many people who cannot access funding, and when they do, sometimes a living allowance is provided, which is often not adequate. You have families living on maybe $1,100 a month...[18]

Larry Gordon pointed to the lack of infrastructure and employment in the north for educated Inuit who want to return and contribute to their communities:

Many times when people leave the North and come back, there is no work for them. They have received an education and a degree, but there is no work for them. They become engineers. The only work that they can actually do is in the South because of their training and background.[19]

13.1.3.2 Health Canada's Programs and Services

Despite some progress in health funding agreements over the past year, witnesses criticized Health Canada's funding arrangements as being complicated, short-term and insufficient to meet the mental health needs of the population.

Witnesses criticized Health Canada's funding arrangements as being complicated, short-term and insufficient to meet the mental health needs of the population. They called for more integrated models of funding between federal departments to support more comprehensive programs that could be sustained over the long-term.

16 1 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/16evc-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

17 21 April 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/13evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

18 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

19 21 April 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/13evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

They called for more integrated models of funding between federal departments to support more comprehensive programs that could be sustained over the long-term.

Irene Linklater noted that, for First Nations, health transfers for mental health programs on-reserve were inflexible, confusing and inadequate:

> *Sometimes the feds flow the money to the province, and the province holds money on a per capita basis for First Nations based on First Nations population in the region. Some of the services that First Nations receive come directly from First Nations and Inuit health branch contribution agreements. [...] Depending on the types and range of services, sometimes the province will enter into an arrangement with a First Nation for specific health cost.*[20]

Onalee Randell, Director of Health, Inuit Tapiriit Kanatami, explained that, for the Inuit, the short-term, unstable and uncertain funding presents significant barriers to the delivery of mental wellness programs:

The short-term, unstable and uncertain funding presents significant barriers to the delivery of mental wellness programs.

> *By the time initiatives with three- to five-year timelines are operational in communities, the funding has run out. It is hard to get qualified staff to give up permanent jobs to go into a project that may end in two years.*[21]

Even the Non-Insured Health Benefits Program fell short of meeting the needs of the targeted populations. Ms Randall indicated that an analysis of 2003-04 financial expenditures on the crisis intervention component of the non-insured health benefits for Inuit found:

Addiction-related programs and services such as the National Native Alcohol and Drug Addictions Program are affected by policies for health transfers that do not allow for unanticipated population growth or for the complex nature of existing needs.

> *... approximately $60,000 of that program was spent on mental health for Inuit communities: $60,000 for communities that have up to 11 times the national average for suicide. There seems to be an inequity. The program is designed to provide short-term crisis counselling. In some of the communities there are no counsellors who can provide that short-term crisis counselling, and in many cases the communities choose not to access the short-term [intervention services]. People come in after a suicide, they spend three days in the community, and then they leave.*[22]

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20 1 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/16evc-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

21 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

22 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

Lorraine Boucher told the Committee that, for First Nations clients with mental health or addiction problems who must travel to access mental health services outside their remote communities, the Non-Insured Health Benefits Program was inadequate:

> *Some of our members have had to stop counselling sessions because of government cutbacks, such as medical transportation cutbacks, and those people are lost in the system. The cost to travel to Edmonton or Peace River is too heavy a burden for them to carry without assistance.*[23]

Irene Linklater also explained how addiction-related programs and services such as the National Native Alcohol and Drug Addictions Program are affected by policies for health transfers that do not allow for unanticipated population growth or for the complex nature of existing needs:

For Inuit trying to access addiction services, a barrier is created by the regional administrative divisions established within Health Canada.

> *… the National Native Alcohol and Drug Addictions Program has not kept pace with the community needs, due to the expectations to intervene on family issues such as family violence, suicide attempts, individual crisis, to provide support and aftercare to those returning from treatment, and a community-wide support following tragedies.*[24]

According to Onalee Randell, for Inuit trying to access addiction services, a barrier is created by the regional administrative divisions established within Health Canada:

> *The Inuit in Nunatsiavut want to work with the Inuit in Nunavik to develop an addictions program based on the Inuit culture and values. Right now, it is difficult to share that information and the resources because of where those jurisdictions get their federal dollars from. The Inuit in Nunatsiavut get it from Altantic Region, and the Inuit in Nunavik get it from Quebec region, and never the two shall meet.*[25]

13.1.3.3 Departmental and Jurisdictional Confusion

In addition to interdepartmental barriers, First Nations and Inuit clients frequently experience difficulties because responsibilities cut across federal departments. Such cross-jurisdictional barriers between federal and provincial or territorial governments prevent forward movement on mental health concerns.

Cross-jurisdictional barriers between federal and provincial or territorial governments prevent forward movement on mental health concerns.

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[23] 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

[24] 1 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/16evc-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

[25] 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

Shawn Atleo, Chief A-in-chut, B.C. Regional Chief, Assembly of First Nations, commented on the lack of a departmental focal point at the federal level, noting that he had talked to three different deputies from three different departments over the previous week about housing.[26] Jennifer Dickson, Executive Director, Pauktuutit Inuit Women's Association, told the Committee that she was obliged to deal with six independent federal departments on a weekly basis for various programs, policy and projects.[27]

Jules Picard, Social Services Coordinator, First Nations of Quebec and Labrador Health and Social Services Commission told of a cross-jurisdictional situation that involved a young person with schizophrenia who was in trouble with the law and needed medication. A setback occurred when it was determined that "Health Canada cannot pay for that young person's medication because he is the responsibility of the provincial prison system."[28]

There is enormous uncertainty when people seek financial resources for services and try to determine whether Indian Affairs, Health Canada or the province has responsibility for payment.

Susan Levi-Peters, Chief of Elsipogtog First Nation, New Brunswick, described the enormous uncertainty when people seek financial resources for services and try to determine whether Indian Affairs, Health Canada or the province has responsibility for payment.

> *When we go to the provincial level, the province tells us it is not our responsibility, it is the federal government. We go to the federal government and they tell us, "We give the money to the province, go to the province." We are the people who are in limbo.*[29]

Ian Potter emphasized that there is currently a focus among governments on cross-jurisdictional integration:

> *The integration of the federal services with provincial services would reduce duplicative services or incidence of services that do not fit together. Service would then be truly focused on the needs of the patient so that the system is clear and not broken up by jurisdictional differences.*[30]

However, Valérie Gideon, Director of Health and Social Development, Assembly of First Nations, expressed concern over such integration:

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26 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

27 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

28 21 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/23evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

29 11 May 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/15evf-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

30 20 April 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/13eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

> *It is our opinion that this could be misconstrued as an off-loading of federal responsibility, certainly something that has often been communicated to us by our regions and our communities.*[31]

Ian Potter also noted the need for cross-departmental integration within the federal government between Health Canada and Indian and Northern Affairs Canada. For example, to increase Aboriginal health human resources, he argued that existing bursaries and scholarships for professional medical programs must be connected to educational programs earlier in the system that are overseen by Indian and Northern Affairs Canada, "starting in grade school, so that Aboriginal people see this as a realistic opportunity."

The Auditor General of Canada has repeatedly criticized Health Canada and Indian and Northern Affairs Canada for not having clearly established legislative authority for programs and services directed to First Nations and Inuit. In particular the Auditor General has noted that the absence of specific enabling legislation for the Non-Insured Health Benefits program "left a gap in the definitions of purpose, expected results and outcomes of program benefits." Health Canada was urged to seek "a renewed mandate for the program to clarify the authority base, purpose and objective of the program."[32]

The Auditor General also pointed out that, although the *Indian Act* sets out requirements for determining who is a "status Indian" and detailing federal jurisdiction over them collectively, it does not specify the programs and services to be provided. Both Indian and Northern Affairs Canada and Parliament were reminded that:

> *The lack of substantive legislative authority could undermine parliamentary control and accountability. It precludes parliamentary debate on important questions such as whether a social assistance program for on-reserve Indians should address reducing the demand for services in addition to supplying the services, and what the appropriate benefits ought to be. In addition, it does not provide an instrument for Parliament to hold the Department accountable against program authorities, beyond those approved by the Treasury Board.*[33]

13.1.4 Committee Commentary

As noted earlier, in the following chapter (Chapter 14), the Committee addresses the need for a comprehensive approach to the mental health of all Aboriginal peoples. There, we emphasize the significance of the proposed creation of a National Aboriginal Advisory Committee as part of the Canadian Mental Health Commission. We also point to the need for more transparent reporting of actions via a federal interdepartmental committee of the deputy ministers responsible for all programs and services for all Aboriginal peoples.

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[31] 21 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/23evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

[32] Auditor General of Canada, *Health Canada — First Nations Health*, Chapter 13, October, 1997, http://www.oag-bvg.gc.ca/domino/reports.nsf/html/ch9713e.html#0.2.L39QK2.4FNW9F.4QDJQE.ZG.

[33] Auditor General of Canada, *Indian and Northern Affairs Canada — Social Assistance*, 1994, http://www.oag-bvg.gc.ca/domino/reports.nsf/html/9423ce.html#0.2.L39QK2.6NA0GI.V1SJQE.ZL.

The *Blueprint for Aboriginal Health* document tabled at the First Ministers' Meeting of November 2005 reiterated previous commitments to clarify issues related to the respective roles and responsibilities of federal, provincial and territorial governments.[34] However, First Nations and Inuit clients have a particular historical relationship with the federal government and their multi-dimensional concerns require specific attention through federal institutional avenues. The Committee is acutely aware that, while some past and current federal initiatives have targeted the mental health of First Nations and Inuit, the ongoing expenditures for federal programs and services have not created the anticipated positive outcomes. The Committee perceives a huge gap between the financial commitments of the federal government and concrete results of benefit to First Nations and Inuit people.

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The Committee believes that some forum for objective oversight is needed with respect to the mental health of First Nations and Inuit, an independent mechanism that would function like an ombudsman.

The Committee believes that some forum for objective oversight is needed with respect to the mental health of First Nations and Inuit, an independent mechanism that would function like an ombudsman. It should be able to undertake investigations to hold the federal government accountable for providing appropriate and adequate programs and services and for the results they achieve.

Other federal client groups such as federal offenders, Canadian Forces and RCMP members already have access to an entity that will systematically investigate, recommend and ensure appropriate responses to their concerns. First Nations and Inuit clients need a comparable specific avenue of redress when interacting with federal departments that have a major impact on their mental as well as their physical health.

The Committee therefore recommends:

69	**That the federal government establish a federal entity for First Nations and Inuit clients, similar to the Correctional Investigator, the Canadian Forces Ombudsman, or the RCMP External Review Committee;** **That this entity be authorized to investigate individual complaints as well as systemic areas of concern related to federal provision of programs and services that have an impact on the mental wellbeing of First Nations and Inuit;**

[34] Health Canada, *Blueprint on Aboriginal Health: A 10-Year Transformative Plan*, Prepared for the Meeting of First Ministers and Leaders of National Aboriginal Organizations, 24-25 November 2005, a Work in Progress, 2005, http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/2005-blueprint-plan-abor-auto/plan_e.pdf.

That the person responsible for this entity be, if possible, of aboriginal origin;

That this entity provide an annual report to Parliament.

The Committee was dismayed to note that, under the 2005 *Blueprint on Aboriginal Health*, detailed reporting on the combined outcomes of federal and provincial programs and expenditures on the health of First Nations, Inuit, and Métis peoples will not take place until 2010-2011.[35] At present, the data from Indian and Northern Affairs Canada and Health Canada is limited and is focused primarily on First Nations. For example, spending information uses the combined term of 'First Nations and Inuit' and does not identify the amounts of money spent on each group; the implication is that spending is proportional to the size of each group's population. There is no reliable evidence useful for developing and evaluating programs and services for Inuit given that the data are merged with those of First Nations or other Aboriginal groups.

The Committee was dismayed to note that, under the 2005 *Blueprint on Aboriginal Health*, detailed reporting on the combined outcomes of federal and provincial programs and expenditures on the health of First Nations, Inuit, and Métis peoples will not take place until 2010-2011.

There is no reliable evidence useful for developing and evaluating programs and services for Inuit given that the data are merged with those of First Nations or other Aboriginal groups.

Although the federal government has pledged to develop comprehensive reporting based on distinct health indicators for each Aboriginal group, the Committee is concerned that Parliament and departments will continue to make decisions over the next five years without access to full information.

Thus, the Committee recommends:

70 **That Indian and Northern Affairs Canada, Health Canada and any other departments with direct program and service responsibility for First Nations and Inuit clients develop an annual inventory of their respective programs and services currently and for the last five years.**

That the inventory include a clear description of: each program or service by fiscal year; the criteria for eligibility; the number of First Nations and Inuit clients respectively served by the program by geographical location; the amount of funding allocated and the amount spent; and any evaluation of outcomes related to the determinants of mental health.

That the inventory be reported to Parliament annually starting in 2008.

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35 *Ibid.*

Most importantly, the Committee believes that the current configuration of federal departments with their respective legislative or policy bases are not now promoting positive change for First Nations and Inuit. Since the initial transfer of the control and administration of medical services for Indians and Inuit from the Department of Indian Affairs to the Department of National Health and Welfare in 1945, there has been little improvement in the health status of this population. The federal government has had ample time to clarify its own role and responsibilities through legislation and to develop policies to reduce interdepartmental confusion. It is time to take significant steps to rectify the interdepartmental fragmentation that contributes to the overall poor health status of First Nations and Inuit.

The federal government has had ample time to clarify its own role and responsibilities through legislation and to develop policies to reduce interdepartmental confusion. It is time to take significant steps to rectify the interdepartmental fragmentation that contributes to the overall poor health status of First Nations and Inuit.

The Committee believes strongly that a comprehensive population health approach is essential to reinforce mental health among First Nations and Inuit. The separation of programs and services between Health Canada and Indian and Northern Affairs Canada does not make sense. The Committee believes the services currently offered by Indian and Northern Affairs Canada for housing, education, and income support must be connected to services offered by Health Canada related to the promotion of healthy child development and of coping skills aimed at reducing addiction and suicide. At present, these programs and services are uncoordinated and the departments compete for budget allocations. A dramatic change is needed to ensure that First Nations and Inuit receive an inclusive range of programs and services related to health determinants and linked to positive outcomes. The change must be real transformation of the existing situation, not simply a minor adjustment.

The Committee believes the services currently offered by Indian and Northern Affairs Canada for housing, education, and income support must be connected to services offered by Health Canada related to the promotion of healthy child development and of coping skills aimed at reducing addiction and suicide.

The Committee realizes, however, that any change in the delivery of programs and services that incorporates a clear legislative base requires full consideration of the potential options and their implications. Thus, the Committee recommends that the federal government conduct an objective and independent examination into the best way to provide programs and services crucial for the promotion and maintenance of the health of First Nations and Inuit, with careful thought to the requisite legislation. At this point, the Committee cannot say with certainty which of the following options would be the best approach:

- Should the current structures be maintained with significant modifications to the way that Health Canada and Indian and Northern Affairs Canada deliver programs and services;

- Should the responsibilities of Health Canada's First Nations and Inuit Branch be transferred to Indian and Northern Affairs Canada; or

- Should specific resources be transferred, with appropriate accountability and evaluation criteria, to either First Nations (and Inuit) authorities or to provincial (and territorial) governments?

The Committee recommends:

71	**That the federal government immediately establish an independent study into the federal provision of programs and services relevant to the overall health of First Nations and Inuit;** **That this study examine various alternatives for the provision of these services; provide clear assessments of these alternatives; and present a comprehensive report with recommendations to Parliament in 2008.**

13.2 FEDERAL OFFENDERS

> *…incarcerating mentally ill people in jails and prisons is cruel, unjust and ineffective. Prisons do not have adequate or appropriate facilities, resources or medical care to deal with the mentally ill. Poorly trained staff is unable to handle the difficulties of mental illness. The mentally ill suffer from illogical thinking, delusions, auditory hallucinations, paranoia and severe mood swings; they do not always comprehend the rules of jails and prisons. They are highly vulnerable and prone to bizarre behaviour that prison staff must deal with and inmates must tolerate. —Bonita Allen, mother of bipolar son*[36]

13.2.1 Federal Responsibility

Correctional Service Canada (CSC) is responsible for administering sentences imposed by the courts that are two years or longer. The *Canada Health Act* explicitly excludes "a person serving a term of imprisonment in a penitentiary as defined in the *Penitentiary Act*" from the definition of insured persons covered under provincial health care plans.[37] The federal government is directly responsible for the provision of health care services to inmates in federal institutions.

A comparison between admissions to federal institutions in 1967 and then again in March 2004 indicates that there has been a 60% increase in the number of offenders with mental disorders.

— *Howard Sapers*

Almost half of those with substance abuse problems have another concomitant disorder; the rate of suicide is considerably higher among inmates than in the general population.

In 1992, the *Corrections and Conditional Release Act* (CCRA) replaced the *Penitentiary Act.* The CCRA defines "mental health care" and requires

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[36] 6 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/18eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

[37] *Canada Health Act*, 1984, Chapter C-6, Section 2 — Interpretation, http://laws.justice.gc.ca/en/C-6/17077.html#rid-17084.

the provision of essential health care, and "reasonable access to non-essential mental health care that will contribute to the inmate's rehabilitation and successful reintegration into the community."[38] A Commissioner's Directive on Health Services indicates that essential health services include the provision of both acute and long-term mental health care services.[39] The legislation also requires consideration of "an offender's state of health and health care needs" when decisions are made relating to placement, transfer, administrative segregation and disciplinary matters as well as in preparing for release and during supervision.

The CSC departmental performance report for the period ending March 2005 states:

> On any given day in 2004/05, CSC was responsible for approximately 12,600 offenders in federal custody and approximately 8,200 offenders serving part of their sentence in the community under supervision.[40]

Francoise Bouchard, Director General, Health Services, Correctional Service of Canada, reported that a high percentage of offenders have mental health problems.

About 22% of adult offenders would likely be diagnosed with FASD.
— ***Howard Sapers***

> *Twelve percent suffer from a serious mental disorder which requires immediate intervention. The percentage of offenders with the diagnosis of mental disorder on admission has risen 61% in seven years, and during the same period the number of offenders on prescribed medication has increased by 80%.*[41]

Howard Sapers, Correctional Investigator of Canada, mandated by the *Corrections and Conditional Release Act* to act as an Ombudsman for federal offenders, reiterated the high prevalence rates of mental illness and addiction problems among inmates:

> *A comparison between admissions to federal institutions in 1967 and then again in March 2004 indicates that there has been a 60% increase in the number of offenders with mental disorders. It breaks down as follows: 57% for male and 65% for female. The prevalence increases to nearly 84% if we include substance abuse in those figures.*[42]

Almost half of those with substance abuse problems have another concomitant disorder; the rate of suicide is considerably higher among inmates than in the general population. With respect to Foetal Alcohol Spectrum Disorder, Howard Sapers reported that "data obtained

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38 *Corrections and Conditional Release Act*, 1992, c. 20, http://laws.justice.gc.ca/en/C-44.6/.

39 Correctional Service Canada, *Commissioner's Directive*, "Health Services," Number 800, 2004, http://www.csc-scc.gc.ca/text/plcy/cdshtm/800-cde_e.shtml.

40 Correctional Service Canada, *Performance Report for the period ending March 31, 2005*, p. 12, http://www.tbs-sct.gc.ca/rma/dpr1/04-05/CSC-SCC/CSC-SCCd45_e.pdf.

41 23 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

42 7 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/19eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

from youth facilities across Canada estimate that about 22% of adult offenders would likely be diagnosed with FASD."[43]

13.2.2 Federal Programs and Services

Correctional Service Canada differentiates between ongoing correctional programs for general offenders who are not living with a mental illness, and specific programs for those in need of mental health services for such conditions as anti-social personality behaviour.[44]

While the current capacity to assess and address mental health problems of offenders is limited, CSC is developing a continuum of care encompassing four key areas:[45]

- mental health assessment of offenders on arrival to establish treatment plans, facility placement, and data collection for future planning;
- regional treatment centres (five currently exist) with consistent hospital status, accreditation, number and types of staff, admission criteria and security requirements; which identify clientele (such as those with FASD and personality disorders diagnoses) who need specific treatment interventions;
- regular mental health services in institutions, as well as some institutional intermediate-care mental health units to accommodate and serve those who need more structure and support but not hospitalization;
- community mental health strategy to provide continuity of care to offenders when released, including the development and implementation of specialized services and supports to address employment, accommodation, and particular mental health needs.

The *Mental health Strategy*, approved by the CSC in the summer of 2004, has languished.

In November 2005, the Annual Report of the Correctional Investigator called for Correctional Service Canada to commit adequate funding to its *Mental Health Strategy*:

> The Strategy, approved by the CSC in the summer of 2004, has languished. No funding has been committed for the three front-end components of the plan: comprehensive clinical intake assessment; improvement to the Service's current Treatment Centres; and intermediate mental health-care units within existing penitentiaries to provide ongoing treatment and assessment during the period of incarceration. Funding secured for the fourth component,

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43 7 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/19eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

44 For additional material on mental health, see Dr. Brent Moloughney, "A Health Care Needs Assessment of Federal Inmates in Canada," *Canadian Journal of Public Health*, Vol. 95, Supplement 1, March/April, 2004, http://www.cpha.ca/english/cjph/inmates/CJPH_95_Suppl_1_e.pdf.

45 23 February, 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

community mental health services to support offenders on conditional release, has not yet reached communities.[46]

While the stated policy objective of the Commissioner's Directive on Health Services is "to ensure that inmates have access to essential medical, dental and mental health services in keeping with generally accepted community practices," in practice, mental health care at the reception centres, treatment centres and community health services is generally not available.[47]

In practice, mental health care at the reception centres, treatment centres and community health services is generally not available.

13.2.2.1 Reception Centres

The Directive's requirements for standards of care at a reception centre specify that every offender is to receive, within 2 working days of arrival, a nursing assessment that includes a review of acute mental as well as physical health. The main purpose of the initial mental health assessment, however, is to ascertain the level of security risk posed by the offender rather than to determine the full extent of any mental health concerns. Standard suicide risk assessment is also done on entry. If potentially suicidal, the individual can be put under observation for a period of time, and be reassessed accordingly. A comprehensive health status nursing assessment is to occur within 14 days.

The main purpose of the initial mental health assessment, however, is to ascertain the level of security risk posed by the offender rather than to determine the full extent of any mental health concerns.

After admission, offenders reside in the reception centre for the first three months where they receive regular medical care. If the individual requires medication for an identified mental health problem, the nurse can refer them to the institutional physician for further review. If behavioural problems occur, further assessment by a psychologist might be required. Psychiatrists can also meet with offenders in the reception centre.

13.2.2.2 Treatment Centres

If significant mental health problems develop during the time in reception, or if there is a pre-existing diagnosis on entry, offenders may be admitted to one of the five existing regional treatment centres. These centres also deliver programs to sex and violent offenders.

Care in the treatment centre is provided on a 24-hour basis. The individual is stabilized, medication is analysed, and a further assessment is done to determine if transfer to a regular institution is possible. Prior to transfer, the health service file is reviewed to identify all health problems to ensure continuity of care and fitness for program placement at the receiving institution.

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[46] Office of the Correctional Investigator, *Press Release*, "Reports Highlights Dramatic Increase in Numbers of Inmates Mentally Ill — Implementation of National Strategy Urged to address Crisis," 4 November 2005, http://www.oci-bec.gc.ca/release-20051104_e.asp.

[47] Correctional Service Canada, Commissioner's Directive, "Health Services," Number 800, 2004, http://www.csc-scc.gc.ca/text/plcy/cdshtm/800-cde_e.shtml.

While continuity of care is the goal of the assessment, few federal offenders receive the treatment they require because of the lack of specific mental health services at the necessary levels.

While continuity of care is the goal of the assessment, few federal offenders receive the treatment they require because of the lack of specific mental health services at the necessary levels.

13.2.2.3 Regular Institutions

Once an offender is stabilized and assigned to a regular institution, whether a maximum, medium, or minimum security institution, health care personnel oversee each individual. There is no dedicated funding or specialized service for mental health, however.

13.2.2.4 Community Health Services

Offenders on full parole, statutory release and day parole residing in a Community Residential Facility, receive essential health services paid by the applicable provincial health care plan. Pre-release arrangements include application for provincial health care coverage.

Those who reside in a Community Correctional Centre are provided with essential health services by Correctional Service Canada. CSC is also responsible for "other non-insured health care expenses, for offenders residing in a Community Correctional Centre or Community Residential Centre who are unemployed and have no other source of income and who are otherwise ineligible for all other forms of government/community assistance."[48] In addition, it is responsible for "non-insured, mental health treatment costs, as stipulated by the National Parole Board or the Correctional Plan, for all conditionally released offenders."

13.2.3 Assessments of Client Group Needs

13.2.3.1 Facilities

Witnesses seriously doubted the capacity of Correctional Service Canada to meet the needs of offenders with mental health issues through its five existing treatment centres. Howard Sapers noted that:

Witnesses seriously doubted the capacity of Correctional Service Canada to meet the needs of offenders with mental health issues through its five existing treatment centres.

> *CSC currently has bed space in their treatment centres to respond to the needs of less than 6% of the inmate population. The Service's own estimates are that the need is for about 12%.. So, current capacity is less than 50% of identified need.*[49]

Natalie Neault, Director of Investigations, Office of the Correctional Investigator Canada, observed that several treatment centres were not capable of providing services to maximum security offenders. She referred to twelve offenders, all in long term segregation with clear symptoms of mental illness, who were repeatedly refused admission at the Shepody Treatment Centre in Dorchester, New Brunswick, because it was not structured for

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48 *Ibid.*

49 7 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/19eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

maximum security. In this situation, even when the inmates do receive a visit from a psychologist, the purpose of the visit is not the treatment of mental illness but assessment of the likelihood of suicide:

The facilities and services available to meet the needs of offenders for mental health care should be comparable to the same standards for mental health care as for those provided to the general population.

> *Moving them out to another region away from their community-which is often all the support they have, and that in itself is very often very limited- is not consistent with the whole purpose of being able to reintegrate these individuals. They remain in segregation units, seeing a psychologist once a month to make sure that they are not suicidal.*[50]

Robert Miller, Chief of Psychiatry at the Vancouver Island Health Authority argued that the facilities and services available to meet the needs of offenders for mental health care should be comparable to the same standards for mental health care as for those provided to the general population:

> *... those in need of hospital care should be treated in hospital and not in prison. Further, when in correctional facilities where people are treated, not everybody needs to be in the hospital. Outpatient mental health care too can be given in prison, but that treatment should be equitable and to the same standard as is available in the local community.*[51]

13.2.3.2 Community Integration

The failure to integrate or even coordinate services that involve various provincial and federal government agencies leaves some individuals without necessary medication and at risk of relapsing into crime.

For offenders with an identified mental health diagnosis who are under treatment and need follow-up by a psychiatrist, Correctional Service Canada tries to assure continuity of service after release. This involves finding a psychiatrist, clinic or hospital that will see the offender upon release and engaging community services in the community release plans. Problems can occur if the offender decides not to go to appointments or to the referral clinic; if the services do not accept the referral; or if the services are not available at the time and place of release. When released to residency in a CSC community centre, services are provided until offenders have left the institutional setting entirely.

The reality is that the community-based services and interventions are limited and because of the prevailing stigma, many difficulties arise in obtaining access to services for offenders living with a mental disorder. Michael Bettman, Acting Director General, Offender Programs and Reintegration, Correctional Service of Canada noted that stigma can be a major barrier to integration:

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[50] 7 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/19eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

[51] 7 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/19evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

> *Basically, I think our biggest challenge is, to a large extent, that stigma. These offenders are part of our community and people do not really recognize it. They want to encapsulate them, not only in a prison but even when they are in the community, and they say that their mental health care is the government's responsibility, it is not our town's or city's responsibility, and as a result, we are often left alone trying to service the needs of our offenders.*[52]

The failure to integrate or even coordinate services that involve various provincial and federal government agencies leaves some individuals without necessary medication and at risk of relapsing into crime. Bernard Galarneau, Psychologist, Policy Director, Shepody Healing Centre pointed out that:

> *Mentally disordered offenders who are receiving psychiatric medication, and who are released from prison, typically have two weeks of medication supply. How quickly can they be seen by a physician or a psychiatrist to have their prescription renewed?*[53]

Jocelyn Greene, Executive Director, Stella Burry Community Services, noted that an innovative community support program based on a home support model for female offenders with complex mental problems offered the prospect of significant savings for both the prison system and the health care system:

> *An evaluation of the program has shown a dramatic reduction in hospital and incarceration rates. [...] the highlight is the decrease in prison days, which was 73%, and the decrease in hospital bed days, which was 39.2%.*[54]

13.2.3.3 Human Resources

Ensuring that there are adequate human resources available to provide mental health services is complicated by the multiplicity of tasks trained professionals are asked to undertake. Françoise Bouchard indicated that there are:

Although inmates in segregation are supposed to be seen once a month by a psychologist, Natalie Neault pointed out that this is not possible.

> *... about 250 psychologists working in the Correctional Service Canada. However, psychologists do not provide only mental health services. They also carry out risk assessment for correctional purposes. In fact, most of the activities of the psychologists within CSC are directed to the risk assessment part of the correctional agenda.*[55]

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52 23 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

53 11 May 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/15evf-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

54 15 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/22evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

55 23 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

Bernard Galarneau, an institutional psychologist at Shepody Healing Centre, explained that, the workload was heavy and focussed more on risk assessment than on mental health:

> *With a caseload of anywhere from 100 to 200 inmates there is little time for genuine psychotherapy. You mostly work as a firefighter. You extinguish fires, crises as they arise, and you do a lot of risk assessments.*[56]

Although inmates in segregation are supposed to be seen once a month by a psychologist, Natalie Neault pointed out that this is not possible:

> *... there is a waiting list as long as my arm in terms of offenders who want psychological services, and there are very limited resources. There are two psychologists for a population of nearly 300 inmates.*[57]

Christine Davis, President, Canadian Federation of Mental Health Nurses, argued for more training and an expanded role for nurses:

> *With proper training, nurses within the prison environment could play a more active role in the area of mental health assessments, evidence-based practice and long-term care of the inmate with mental health issues. Too often, people are incarcerated because of the lack of forensic beds. If nurses providing physical care were supported to perform mental health assessments and treatments, there would be less pressure on forensic institutions and more chance that persons within the justice system affected by mental illness could be directed toward care sooner.*[58]

Witnesses such as Kim Pate, Executive Director, Canadian Association of Elizabeth Fry Societies, recognized that it is not feasible to train all staff in how to perform mental health assessments, but she stressed that it is extremely important to identify offenders with mental health problems and to get them the mental health care they need quickly. She noted that individuals can improve within a short time when they are "seen through the lens of the mental health issues/psychiatric label, not the lens of criminality."[59] For Howard Sapers, staff must be trained to distinguish "whether you are dealing with a mental health crisis or a security crisis when you see an inmate who is acting out."[60]

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56 11 May 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/15evf-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

57 7 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/19eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

58 20 April 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/13eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

59 16 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/06eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

60 7 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/19eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

13.2.3.4 Specific Offender Groups — Segregated, Female, Aboriginal

Segregated offenders are more likely to be recipients of inappropriate assessment; it is less likely that their mental health needs will be fully recognized. Howard Sapers noted that offenders who are locked up in segregation for up to 23 hours a day in maximum security institutions are often intellectually challenged or "present behavioural problems, learning disabilities and/or symptoms of attention deficit hyperactivity disorder, ADHD, or fetal alcohol spectrum disorder, FASD." He painted a bleak picture of the prospects for these offenders within the correctional system:

Segregated offenders are more likely to be recipients of inappropriate assessment; it is less likely that their mental health needs will be fully recognized.

> *These offenders are unable to complete regular programs, they are preyed upon by other offenders, they end up in segregation, they have limited coping skills and they are usually classified as maximum security. They do not have the ability or skills required to focus and concentrate in order to complete regular programming. They are very vulnerable and their segregation is usually for a much longer period of time than others in segregation. They are usually referred to see the psychiatrist, who typically finds no evidence of a psychiatric disorder, per se, and identifies these individuals as exhibiting a behavioural problem. These offenders therefore do not meet the criteria that would allow them to benefit from services provided in treatment centres, so they stay in the general institutions. They have limited coping skills, which may cause them to withdraw, self-injure, set fires, attempt or commit suicide, and in some extreme situations assault others or guards.*[61]

Several witnesses called for staff training on how to provide appropriate interventions for offenders with disorders that might result in segregation and also for appropriate training for staff working with those who are segregated. Natalie Neault explained the need to ensure that those with learning disabilities are properly assessed on reception as they "have difficulty following orders from the officers and thus end up being charged, in segregation, and receiving a disciplinary sanction."[62] Kim Pate described her experience with segregated female offenders:

Natalie Neault explained the need to ensure that those with learning disabilities are properly assessed on reception as they "have difficulty following orders from the officers and thus end up being charged, in segregation, and receiving a disciplinary sanction".

Women were particularly affected by deinstitutionalization as well as by cuts in social programs, suggesting that for some women prison is seen as an alternative care system.

> *... I have been on my knees in front of a segregation cell, talking to someone through a meal slot, trying to convince her to stop smashing her head on the*

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61 7 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/19eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

62 7 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/19eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

> *wall, and had staff say that they are told to count to 20, because that is when it is no longer just an attention-getting behaviour, it may be life-threatening. That is not because those staff are ill-intentioned, but they have been trained to believe that up to a certain point, it may just be a manipulative behaviour.*[63]

Although women constitute a small group, an estimated 400 in the federal offender population, they have particular mental health concerns. Howard Sapers pointed to a study comparing admissions to federal institutions in 1967 and 2004 that indicated a 65% increase in the number of female offenders with mental disorders, a figure that increases if substance abuse is included. He also noted:

> *Correctional Service of Canada recognizes that women in federal institutions have a higher rate of self-mutilation and attempted suicide than do their male counterparts. The CSC research branch found that more than two-thirds of women in maximum security had previously attempted suicide, compared with 21% of maximum security males. So it is about three times.*[64]

Kim Pate argued that women were particularly affected by deinstitutionalization as well as by cuts in social programs, suggesting that for some women prison is seen as an alternative care system:

> *With the cuts to national standards for health care, social services and education occasioned by the elimination of the Canada Assistance Plan [...], we also saw increased numbers of people who fell through all of those service cracks, and ended up in the criminal justice system. That is because it is really the only system that cannot close its doors and say, "No, we are full, our beds are full," and it is not difficult to characterize behaviour that is symptomatic often of mental illness as also criminal.*[65]

Significant cost saving could be achieved by reaching Aboriginal children in a positive way before they interact negatively with the law.

Several witnesses also pointed to the over-representation of Aboriginal peoples in the criminal justice system. According to Michael Bettman, specific programs have been designed by Aboriginal people and often delivered by Aboriginal people to Aboriginal offenders. He noted that:

> *... Aboriginal people represent 3% of the population but 17% of our offender population. In the Prairie region, that number is approaching 65%.*[66]

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63 16 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/06eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

64 7 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/19eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

65 16 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/06eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

66 23 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

Darrell Downton, Co-Chair, Mental Health and Addictions Advisory Committee, Five Hills Regional Health Authority, emphasized the need for prevention. He insisted that significant cost saving could be achieved by reaching Aboriginal children in a positive way before they interact negatively with the law:

> *A lot of times there may be programs that are in place once they are in the justice system but it is much more important to have that intervention process and plan in place to reach these children before they ever get into the justice system. It saves $50,000 a year plus many other things, in terms of benefits to society.*[67]

13.2.3.5 Addictions

According to Michael Bettman, close to 80% of federal offenders had a substance abuse problem that is connected to reoffending. He emphasized that Canada's substance abuse program is internationally accredited and is emulated by various European countries:

> *We have a national substance abuse program in our maximum, medium and minimum security institutions, with maintenance afterwards. These are programs focused on harm reduction strategies for the offender to reduce and prevent further substance abuse. These programs are followed up by maintenance throughout the offender's sentence, both in the institution and in the community, once they are released.*[68]

Howard Sapers recommended that CSC implement various measures to improve the situation for offenders with substance abuse problems:

> *... a prison-based needle exchange program to deal with the public health risks associated with the growing infection rate of hepatitis-C and HIV. There are several jurisdictions in Europe that have prison-based needle exchange programs. They work, in the sense that infection rates are down and the release of healthy inmates has increased. There have been no reported increases either in the incidence of drug abuse within prisons or the use of syringes in assaults...*[69]

Michael Flaxman, a volunteer with the From the Heart Committee in Toronto, called for those offenders with histories of non-violent drug related crimes to be separated and provided with different programs that focus primarily on addictions:

The lack of continuity between institutional and community based programs and services leads to various problems for offenders who are released.

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67 2 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/17eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

68 23 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

69 7 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/19eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

> *... why not have a low-medium security facility that deals with non-violent drug-related crimes that delivers programs along a specific continuum that are specific to the needs of addicts. These individuals tend to be serving shorter sentences than others, and with accelerated parole review at which they are eligible for day parole at the one-sixth point of their sentence, their focus can be solely on their addictions.*[70]

The lack of continuity between institutional and community based programs and services leads to various problems for offenders who are released. According to Ron Fitzpatrick, Executive Director, Turnings, when an offender who has been on methadone is released, an equivalent program to that available within the correctional milieu must be immediately available in the community, yet frequently it is not:

> *He needs to be in a methadone program because he has been on it these five years. If he does not get in it right away because of waiting lists, he can be back on the street using street drugs because that is his only alternative, and he ends up back in jail. If he gets sentenced to our provincial prison for stealing for drugs, he goes to prison and he may or may not get into a methadone maintenance program.*[71]

13.2.4 Committee Commentary

The Committee has one primary goal for federal offenders — and by extension, for provincial correctional populations — it wants the standard of care for mental health within correctional institutions (and in post-release settings) raised to be equivalent to that available to "non-offender members" of the general community. Not meeting this goal is to condemn far too many offenders to a life of going through a revolving door, repeatedly in and out of prison. If the goal of incarceration is rehabilitation as well as public safety, this goal must be met. If it is not, the conclusion must be that Correctional Service Canada places a much higher priority on retention than on rehabilitation.

The Committee has one primary goal for federal offenders — and by extension, for provincial correctional populations — it wants the standard of care for mental health within correctional institutions (and in post-release settings) raised to be equivalent to that available to "non-offender members" of the general community. If the goal of incarceration is rehabilitation as well as public safety, this goal must be met.

The needs of incarcerated people suffering from mental illnesses and addiction can only be met through a significant change in the programs, funding and attitude of CSC.

The Committee urges Correctional Service Canada to give a higher priority to mental health and addiction needs – to devote as much attention to these needs as it does to risk assessment and security issues, to ensure that treatment and rehabilitation are smoothly coordinated.

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[70] 15 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/05evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

[71] 14 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/22eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

The Committee understands that the needs of incarcerated people suffering from mental illnesses and addiction can only be met through a significant change in the programs, funding and attitude of CSC. At the outset it requires a thorough mental health screening when an offender accesses a federal penitentiary. It requires funding to provide the programs and services to meet the mental health needs of the prison population. It requires that CSC 'walk the talk' with respect to the priority to be given to rehabilitation versus retention for public safety. The Committee also recognizes that consistent data collection and careful analysis as well as an expanded research capacity related to mental health will be necessary. In summary, the Committee urges Correctional Service Canada to give a higher priority to mental health and addiction needs – to devote as much attention to these needs as it does to risk assessment and security issues, to ensure that treatment and rehabilitation are smoothly coordinated.

To achieve equivalent standards of care for mental health for federal offenders within institutions and in post-release settings, the Committee recommends:

72	**That Correctional Service Canada (CSC) develop and implement standard of care guidelines for mental health to be applied within institutions and in post-release settings that are equivalent to those applied in settings accessed by the general population.** **That CSC guidelines be based on the collection of statistical information about federal offenders and their mental health disorders and addictions, including prevalence rates for mental health disorders, type of treatment utilized (psychotherapy, medication, etc.), rate of hospitalization, etc.** **That CSC performance with respect to implementing the guidelines be reviewed annually by an independent external body with mental health expertise such as the Canadian Mental Health Commission (see Chapter 16).** **That data used for the guidelines be compiled and made available to the public and that the raw data be made available to researchers for independent analysis.** **That the performance assessment be reported to Parliament annually starting in 2008.**

With respect to those offenders in need of mental health care and treatment while in regular correctional facilities, the Committee believes all staff should be trained to distinguish between a mental health crisis and a security crisis. Offenders must receive needed psychotherapy and other appropriate therapies from professionals who are trained specifically to deal with mental health issues.

The Committee urges that a full mental health assessment of offenders by trained professionals occur at the time of their arrival at a reception centre, and that it be completed within a shorter time frame than is currently the case. It supports expanded harm reduction efforts along with better treatment services for addicted offenders. Going beyond the existing methadone program, the Committee is in favour of a full assessment of the advantages and disadvantages of establishing needle exchange services with federal institutions.

The Committee recommends:

73	**That Correctional Service Canada conduct a full clinical assessment by an accredited mental health professional of each offender to determine their mental health and/or addiction treatment needs to be completed no later than seven calendar days after their arrival at a reception centre.** **That Correctional Service Canada undertake training of correctional officers and other staff immediately following their appointment to enable them to distinguish between a mental health crisis and a security crisis.** **That Correctional Service Canada make psychotherapy available to offenders, when medically necessary, provided by a psychiatrist, psychologist, clinical social worker or other health care professional who is not responsible for the risk assessment of offenders.** **That Correctional Service Canada increase the capacity of its existing treatment centres with additional beds as well as additional staff.** **That Correctional Service Canada immediately implement expanded harm reduction measures in all federal correctional institutions.**

After the release of offenders to the community, the Committee seeks assurance that Correctional Service Canada will take responsibility for ensuring continuity of care, including access to medication that goes beyond the two-week supply issued on release.

The Committee recommends:

74	**That Correctional Services Canada establish a case management system that ensures that offenders have access to appropriate mental health treatment upon their release, including a requirement to supply, without cost, enough medication to last until their transition to provincially or territorially provided community-based care.**

13.3 CANADIAN FORCES

> *... about half of the people who do have issues are not coming forward to seek help, so we are still working on that. Is there a stigma? There is less than there used to be, but I am concerned that we are creating a two-tiered category of mental illness. It is perhaps acceptable to have an operational stress injury or PTSD [posttraumatic stress disorder]; it is not acceptable to have ordinary depression in the military. —Brigadier-General Hilary F. Jaeger, Surgeon General, National Defence*[72]

13.3.1 Federal Responsibility

Under subsection 91(7) of the *Constitution Act, 1867,* sole responsibility for all military matters, including military health care, is assigned to the federal government. The 1984 *Canada Health Act* specifically excludes "a member of the Canadian Forces" from the definition of "insured persons." They are also excluded from insurance coverage under provincial health care plans and from coverage under the Public Service Health Care Plan.

Through the *National Defence Act,* the Minister of National Defence is given the authority for the management and direction of the Canadian Forces.[73] As explained by Brigadier-General Hilary F. Jaeger, Surgeon General, National Defence:

In comparing the Canadian Forces with the civilian population, she reported the "prevalence of depression in the year preceding the survey was 80% higher than that found in the general population."

> *... the federal government has responsibility for, and authority over, all aspects of health care for regular force members from the time they join until the time they retire, and entitled reservists, including mental health care.*[74]

According to the departmental Performance Report for the period ending 31 March 2005, the size of the regular force numbered 61,715 in 2004-2005.[75] The actual strength of the primary reserve force for 2004-2005 was 25,633 personnel.[76]

While posttraumatic stress disorder is often the primary focus for mental illness in the Canadian Forces, it is not among the three most prevalent disorders.

To determine the burden of mental illness among members of the regular and reserve forces, National Defence and Statistics Canada developed the 2002 Canadian Forces supplement to the Canadian Community Health Survey. This survey permitted comparisons between the

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[72] 23 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

[73] *National Defence Act*, R.S. 1985, c. N-5, http://laws.justice.gc.ca/en/N-5/.

[74] 23 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

[75] National Defence, *Performance Report For the Period ending March 31, 2005*, p. 115, http://www.tbs-sct.gc.ca/rma/dpr1/04-05/ND-DN/ND-DNd45_e.pdf.

[76] *Ibid.*, p. 88; The Primary Reserve is made up of the Naval Reserve, the Army Reserve, the Air Reserve, the Communication Reserve, the Health Services Reserve, the Legal Reserve, and the National Defence Headquarters Primary Reserve List.

Canadian public at large and members of the Canadian Forces with respect to the prevalence of certain mental illnesses, perceptions of well being and the use of services.[77]

Brigadier-General Jaeger noted that members of the regular force reported an annual incidence of mental health problems of about 15% compared to 13% in the reserves and a lifetime prevalence of mental illness of between 30 and 35%.[78] In comparing the Canadian Forces with the civilian population, she reported the "prevalence of depression in the year preceding the survey was 80% higher than that found in the general population."[79]

Furthermore, Brigadier-General Jaeger told the Committee that, while posttraumatic stress disorder is often the primary focus for mental illness in the Canadian Forces, it is not among the three most prevalent disorders:

> *Depression is our leading cause of suffering at 7.6% in the year preceding the survey. Alcohol abuse or dependency hit 4%, and social phobia 3.6%. PTSD was 2.8% and panic disorder 2.2% — all in the regular force, which, generally speaking, has a somewhat worse incidence of mental illness than the reserve forces.*[80]

13.3.2 Federal Programs and Services

Brigadier-General Jaeger reported that the Canadian Forces has engaged in a systematic renewal of its approach to mental health care, and has begun to implement a model of mental health care delivery that addresses multiple factors:

> *We believe in a very holistic look at mental health. We believe that it is that component of health that pertains to cognitive, emotional, organizational and spiritual matters, and is much more than the mere absence of psychiatric illness; so that sets us a fairly high standard.*[81]

In November, 2005, the Office of the Surgeon General released a "backgrounder" providing an update on Canadian Forces Mental Health Programs.[82] The information covered health services delivery, health protection, casualty support, family support, the mental health

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77 National Defence, *Statistics Canada CF Mental Health Survey*, "A milestone," http://www.forces.gc.ca/health/information/op_health/stats_can/engraph/MH_Survey_e.asp.

78 Correspondence from Brigadier-General Hilary F. Jaeger, Surgeon General, National Defence to Senator Michael Kirby, Chair, Standing Senate Committee on Social Affairs, Science and Technology, The Senate, 2 February, 2006 pointed out that, as the survey did not measure all types of mental illness, the true lifetime prevalence is likely higher.

79 23 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

80 23 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

81 23 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

82 National Defence, *News Room Backgrounder*, "Canadian Forces Mental Health Programs — Update," BG 05.037, 10 November 2005, http://www.dnd.ca/site/newsroom/view_news_e.asp?id=1804.

component of Rx2000 (acronym for the Canadian Forces Health Services Reform restructuring project) and partnerships with Veterans Affairs Canada.

13.3.2.1 General Mental Health Services

The Department of National Defence provides Canadian Forces members with non-emergency, outpatient care through base clinics, health care centres and support units at military installations across Canada. These units treat non-life threatening illnesses, perform minor surgical procedures, counsel on minor mental health issues, and provide medication as needed.[83]

Most specialized mental health services are purchased from the provinces.

If the need for services occurs after operational hours, involves a serious medical emergency, or is in a remote geographical location, CF members receive care at civilian hospitals or other health care facilities. Although larger military clinics can provide specialty services for mental health, most specialized mental health services are purchased from the provinces.

The Canadian Forces Health Services Reform *(Rx2000)* is a comprehensive medical restructuring project that includes a mental health component. Recent funding commitments totalling $98 million over six years are expected to enhance CF mental health care delivery through several initiatives:

- Increasing the number of mental health providers available to CF members across the country;
- Developing standardized approaches to the assessment and treatment of key conditions and ensuring all staff is equally comfortable with the preferred therapeutic approaches;
- Refining deployment-related psychosocial screenings to allow for earlier intervention;
- Improving educational outreach services;
- Conducting research to improve practices and to measure outcomes.

13.3.2.2 Operational Trauma Stress Support

Canadian Forces personnel face unique stressors when deployed on combat, conflict resolution, and peacekeeping missions. The duties that are performed as part of the military life can result in the very traumatic experience of multiple casualties, armed attacks, hostage-taking, massacres, deaths of co-workers and civilians, etc.

In 1999, the department opened five Operational Trauma and Stress Support Centres at bases in Halifax, Valcartier, Ottawa, Edmonton, and Esquimault. They focus on psychological, emotional, spiritual and social problems that arise from military operations.

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[83] National Defence, *Canada's Military Health System*, "In-Garrison Health Services," http://www.forces.gc.ca/health/about_us/engraph/in_garrison_e.asp.

In 2002, DND and Veterans Affairs Canada jointly launched the Operational Stress Injury Social Support (OSISS) project, a Canada-wide peer-support network to assist members and former members suffering from operational stress injuries (OSI).

Operational stress injury (OSI) is defined as any persistent psychological difficulty resulting from operational duties performed by a Canadian Forces member and includes posttraumatic stress disorder (PTSD).[84] In 2003, preliminary findings from an evaluation of enhanced post-deployment health screening for CF members on operation in Afghanistan/SW Asia revealed "disturbing levels of impaired physical and mental well-being.[85] On the positive side, many individuals with these problems were identified and referred for care.

13.2.2.3 Stress and Addictions

When duties take them away from their families, both the process of separation and of eventual reunion create particular emotional demands and stresses for CF members. In 2000, the Directorate of Medical Policy at National Defence prepared a series of pamphlets on stress, including deployment stress and reunion stress as well as critical incident stress.[86]

Departmental policies on alcohol and drugs provide guidance on effective interventions.[87] Supervisors are encouraged to recognize early warning signs of alcohol, drug and gambling addiction and to intervene early to prevent later health and safety problems. Initial steps can include educational sessions and the involvement of medical personnel, while addiction counselling and treatment programs can be prescribed by an attending physician.

The department also offers programs to promote mental health and prevent negative behaviours linked to stress, such as addictions, family violence and suicide. The interdisciplinary approach of these programs involves psychiatrists, clinical psychologists, mental health nurses, social workers, addiction counsellors and chaplains, all of whom share responsibility with primary care providers.

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84 Operational Stress Injury Social Support, *Information for Canadian Military, Former and Serving,* "What are Operational Stress Injuries?" http://www.osiss.ca/sitePage.txp?ud_siteSectionId=14347&tx_target=main1131814980596.

85 Mark Zamorski, *Evaluation of an Enhanced Post-Deployment Health Screening Program for Canadian Forces Members Deployed on Operation OPOLLO (Afghanistan/SW Asia): Preliminary Findings and Action Plan,* June 2003, http://www.forces.ca/health/information/op_health/op_apollo/engraph/op_apollo_toc_e.asp.

86 National Defence, Directorate of Medical Policy, series of booklets titled *Preparing for Critical Incident Stress, Preparing for Deployment Stress, Preparing for Reunion Stress*, 2000, http://www.forces.gc.ca/health/information/engraph/health_promotion_home_e.asp?Lev1=2&Lev2=5.

87 National Defence, *Aide Memoire for the Supervisor's Role in Dealing with Alcohol Misuse*, DCOS Force Health Protection, 2004, http://www.forces.gc.ca/Health/Services/health_promotion/PDF/Aide%20Memoire%20for%20the%20Supervisor%27s%20Role%20in%20Dealing%20with%20Alcohol%20Misuse.pdf.

13.2.2.4 Medical Releases

Brigadier-General Jaeger estimated that about 42% of all medically-related time off work among CF personnel was for mental health issues, and that about 23% of CF members who are released for medical reasons have mental illness as their primary diagnosis.[88] She noted that the department is able to adapt work situations to a larger degree than most employers and that this helps to reduce the need to release members from military service:

About 42% of all medically-related time off work among CF personnel was for mental health issues.

> *We can direct part-time work, we can direct work of less stress, and we can direct work of less physical stress.*[89]

Nonetheless, Colonel D. R. Boddam, Canadian Forces practice leader for psychiatry and mental health, National Defence, told the Committee that, while a majority of individuals diagnosed with mental illness return to work after treatment, about 300 people yearly are released for reasons related to mental illness. He noted that National Defence has recently established a project to work with Veterans Affairs Canada:

> *For those people who have sustained a mental injury as a result of their employment, we wish to work together to be able to provide that continuity in a seamless way, from where they start to get care to when they become civilians.*[90]

Brigadier-General Jaeger emphasized that medical releases from the military and employment restrictions are a serious issue for the department as well as for the affected members:

While a majority of individuals diagnosed with mental illness return to work after treatment, about 300 people yearly are released for reasons related to mental illness.

> *About 2300 of our members every year undergo a review of their suitability to continue serving in the Canadian Forces. About 23% of these cases every year are due to mental illness and that perhaps is not surprising. They are disproportionately likely to end up being released from the Canadian Forces.*[91]

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88 Correspondence from Brigadier-General Hilary F. Jaeger, Surgeon General, National Defence to Senator Michael Kirby, Chair, Standing Senate Committee on Social Affairs, Science and Technology, The Senate, 2 February, 2006.

89 23 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

90 23 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

91 23 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

13.3.3 Assessments of Client Group Needs

13.3.3.1 General Mental Health Care

Brigadier-General Jaeger acknowledged the challenge of providing team-based mental health care to meet the needs of CF members. She pointed out that the department will have to double its personnel and that finding trained people to fill these positions will be difficult, since the department will "have to recruit professionals from the civilian sector, where we know there is already an overall shortage of care providers."[92]

Colonel Boddam noted that the dependence upon the civilian health care system to treat more severely ill members is also a concern for CF members with serious mental illness:

> *Psychiatric beds exist at a premium. We do not run our own, and we cannot always readily access such beds. This is a particular concern for us as the highly mobile nature of military careers means that support systems such as extended family and friends of long standing are less likely to be able to provide help when a member is suffering.*[93]

A number of joint efforts of National Defence and Veterans Affairs Canada are intended for still-serving Canadian Forces members as well as those in transition to civilian life. Brigadier-General Jaegar expressed optimism about the current partnership and the goal of consistency in mental health services:

The dependence upon the civilian health care system to treat more severely ill members is also a concern for CF members with serious mental illness.

> *The vision is to have VAC mental health resources available to members of the CF where this makes sense, and CF mental health resources available to VAC where this makes sense. It is desired by us that blended staffing eventually take place.*[94]

13.3.3.2 Mental Health Outcomes

In response to concerns that revealing a mental illness might lead to the termination of a person's military career, rather than having them return to work after treatment, Brigadier General Jaeger said:

The access to, and adequacy of, pensions for individuals who are medically released was also raised as an issue.

> *The vast majority of people who present with a mental illness receive appropriate treatment and go back to work. They are invisible to everyone else. We would like to have a spokesperson that is willing to stand up and say, "I did that." We have General Dallaire, who has been an eloquent spokesperson*

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92 23 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

93 23 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

94 23 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

> *for posttraumatic stress disorder and operational stress injury, who did end up having to take his retirement from the Canadian Forces. However, we would like to have a public example who is willing to be a spokesperson from the other side. With confidentiality concerns, we cannot force people to do that. We can only ask for volunteers.*[95]

The access to, and adequacy of, pensions for individuals who are medically released was also raised as an issue. Brigadier General Jaeger voiced particular concern about stringent eligibility criteria for the Service Income Security Insurance Plan (SISIP).[96] This group insurance plan provides long term disability insurance to Canadian Forces members who become injured or disabled and are medically released:

> *On the question of pensionability, if you are medically released from the Canadian Forces at any point past 10 years of service, you are entitled to an immediate annuity based on the number of years of service, 2% per year of service. If you are released after 16 years of service, it is a 32% pension indexed to the rate of inflation. You are entitled to the Service Income Security Insurance Plan, SISIP, which augments that to 75% of your salary but only if you meet their criterion, which is all-occupation disability. It is a stringent disability to meet.*
>
> *If you make the case with Veterans Affairs that your disability is attributable to military service or has been exacerbated by military service, you will receive a favourable response from their administrators and would be eligible for whatever percent disability you end up being awarded.*[97]

13.3.3.3 Mental Health Redress

In recent years, two avenues have opened for Canadian Forces members with grievances related to mental health and other issues emanating from their work. In 1998, the Minister established an Ombudsman position within the department to investigate complaints and to serve as a neutral third party on matters related to members and employees of National Defence and the Canadian Forces. In 2000, the Canadian Forces Grievance Board was created as a separate, independent civilian administrative tribunal with the power to hear grievances related to various aspects of military life, including entitlement to medical care.

As recently as 2004, the Ombudsman conducted a follow-up investigation on operational stress.[98] He praised the high quality of care provided at Operational Stress Injury Support Clinics; the increased level of funding committed to the treatment of Operational Stress

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95 23 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

96 Canadian Defence Academy, *Moving On — A Handbook for Canadian Forces Members Preparing for Release*, "Chapter 8 — Disability Benefits and Pension," 2002, http://www.cda.forces.gc.ca/er/engraph/mss/handbook/pdf/Eng_Chapter_8.pdf.

97 23 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

98 National Defence Ombudsman Office, *Annual Report 2004-2005*, June 2005, http://www.ombudsman.forces.gc.ca/reports/annual/2004-2005_e.asp#Battle.

Injuries; the successes of the Operational Stress Injury Social Support group that provided peer support to over 1,000 CF members. The Ombudsman's report called for further work, however, including:

> *... training and education to change attitudes about operational stress injuries; communications between the operational chain of command and those who provide treatment to CF members suffering from Operational Stress Injuries; and coordination of OSI training, education and initiatives across the CF.*[99]

The Ombudsman Office of National Defence received multiple complaints about release (218), medical (97) and posttraumatic stress disorder (35) in 2004-2005. The Canadian Forces Grievance Board does not provide clear identification of cases related to mental health issues.[100]

13.3.4 Committee Commentary

The Committee is pleased that the Department of National Defence offers such a wide array of services to Canadian Forces members who may experience mental health problems. The provision of services for family support as well as medical treatment and casualty support is commendable. The Committee is especially supportive of increased efforts to reduce the stress incurred for CF members and their families due to factors such as separation for operational reasons and frequent relocations.

The Committee is pleased that the Department of National Defence offers such a wide array of services to Canadian Forces members who may experience mental health problems.

The provision of services for family support as well as medical treatment and casualty support is commendable.

The Committee is aware that many of these mental health programs and services are relatively new and are dispersed across many military establishments. These initiatives should be adequately evaluated and the results reported to Parliament.

The Committee recommends:

75	**That National Defence develop an annual inventory of its programs and services for mental health;** **That the inventory include a clear description of each program or service with number of clients served, the amount of funding allocated and spent, and any evaluation of outcomes achieved;** **That the inventory be reported to Parliament annually starting in 2008.**

[99] *Ibid.*, section titled "Following up on the CF's Treatment of Members Suffering from OSIs."

[100] Canadian Forces Grievance Board, see case summaries section in index, PTSD did not appear in a search; one drug addiction case was found; http://www.cfgb-cgfc.gc.ca/index-e.php

The Committee understands that many serving members of the Canadian Forces and Canadian Forces veterans as well are reluctant to talk about their traumatic experiences. The Committee believes that the department has a responsibility to provide multiple and frequent opportunities for military members still-serving to address the implications of operational stress injuries. Although social support for Canadian Forces members and their families has improved and their access to necessary programs and services has increased, the Committee believes that more work can be done by the department to enhance the peer support network and, in the longer term, to implement cultural change to ensure early identification and follow-up services to address the needs of both members and their families with operational stress injuries. This includes, not only a focus on posttraumatic stress disorder, but on anxiety disorders and depression as well as other symptoms of stress such as alcohol or drug abuse and family dysfunction.

The Committee believes that more work can be done by the department to enhance the peer support network and, in the longer term, to implement cultural change to ensure early identification and follow-up services to address the needs of both members and their families with operational stress injuries.

The Committee recommends:

76	**That National Defence require that all medical personnel receive mandatory training with respect to operational stress injury and that this training include:** • **proper recording of military and trauma histories;** • **methods to recognize/detect symptoms of operational stress injury;** • **understanding of multiple treatment modalities; and** • **appropriate long-term follow-up processes;** **That National Defence make the information available to National Defence and civilian medical personnel through publications, seminars, or other public forums;** **That National Defence explore measures to encourage more widespread use of peer counselling and increased engagement of family and community.**

The Committee is also concerned about the Reservists who work with National Defence but have a different relationship to the department than do regular Canadian Forces members. When they return from mobilization missions and exercises, they may not have access to the support offered on military bases. The Committee believes that the department has a responsibility to ensure that follow-up services are readily available to Reservists as well. Sufficient time must be allowed for an orderly transition from regular to reserve units, ensuring that Reservists are given adequate medical assessments, with proper evaluation of the potential for operational stress injury. For the department, this may require that the employment commitment for Reservists be extended while they are being properly screened.

The Committee recommends:

—	**That National Defence evaluate and report to Parliament on the programs and services currently available to Reservists for mental health problems resulting from their duties while mobilized, including services for post-traumatic stress disorder and addictions.**

13.4 VETERANS

... good mental health is important for re-establishment, good re-establishment programming is important for mental health. — Brian Ferguson, Assistant Deputy Minister, Veteran Services Branch, Veterans Affairs Canada[101]

13.4.1 Federal Responsibility

For most veterans, Veterans Affairs Canada (VAC) does not provide health insurance to cover services above and beyond those offered by the provinces or territories, although income-qualified veterans may get some additional assistance.

Unlike serving members of the Canadian Forces, veterans are considered to be "insured persons" under the *Canada Health Act* with respect to mental (and other) health services. For most veterans, Veterans Affairs Canada (VAC) does not provide health insurance to cover services above and beyond those offered by the provinces or territories, although income-qualified veterans may get some additional assistance. Veterans with disability pensions do receive financial coverage for treatment of their pensioned condition.

The principal legislative authority for veterans and their health care is found in the *Department of Veterans Affairs Act* and the *Pension Act* and, since 2005, in the *Canadian Forces Members and Veterans Re-establishment and Compensations Act.*[102] Under the *Department of Veterans Affairs Act,* the *Veteran's Health Care Regulations* define health as a state of physical, mental and social well-being. This Act outlines eligibility for multiple benefits including medical care, home adaptations, travel costs for examinations or treatment and other community health care services.[103]

The *Pension Act* defines disability as "the loss or lessening of the power to will and to do any normal mental or physical act." The *Canadian Forces Members and Veterans Re-establishment and Compensation Act* authorizes the Minister to provide job placement assistance, rehabilitation

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101 23 February, 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

102 *Department of Veterans Affairs Act*, R.S. 1985, c. V-1, http://laws.justice.gc.ca/en/V-1/ and *Pensions Act*, R.S. 1985, c. P-6 http://laws.justice.gc.ca/en/P-6/; *Canadian Forces Members and Veterans Re-establishment and Compensation Act*, http://www.parl.gc.ca/PDF/38/1/parlbus/chambus/house/bills/government/C-45_4.PDF.

103 *Veterans Health Care Regulations*, http://laws.justice.gc.ca/en/V-1/SOR-90-594/.

services, vocational assistance and financial benefits, disability awards, and health benefits for Canadian Forces members and veterans.

Brian Ferguson, Assistant Deputy Minister, Veteran Services Branch, Veterans Affairs Canada, described the departmental process that is followed for mental health services:

> *Under the Veterans Health Care Regulations, if a need for health care is related to a pension condition, Veterans Affairs Canada will pay for those treatment benefits directly. For eligible veterans, we will pay for non-pension conditions if the service is not covered under provincial health care plans.*
>
> *With the exception of those services provided at our own Ste. Anne's Hospital, all health services provided to our clients are delivered either by provincial jurisdictions, non-governmental organizations or private registered providers. Through our network of regional and district offices, we have an ongoing relationship with provincial governments.*[104]

As of March 2005, VAC was providing benefits and services to approximately 219,000 clients.[105] These include military personnel and others:

- members of the Canadian Forces and Merchant Navy veterans who served in the First World War, the Second World War or the Korean War;
- certain civilians who are entitled to benefits because of their wartime service;
- former members of the Canadian Forces (including those who served in Special Duty Areas) and the Royal Canadian Mounted Police;
- survivors and dependents of military and civilian personnel.

Speaking specifically about disability pensions and health care, Brian Ferguson reported the number of clients served by the department to be slightly fewer, approximately 209,000 people. He also pointed out the significant increase in Canadian Forces clients among those served by VAC:

> *... 18% of [our clients] are Canadian Forces members and veterans. Their numbers have increased 58% in the last three years and we anticipate having more than 58,000 Canadian Forces clients by the year 2013.*[106]

Mr. Ferguson explained that a survey of Canadian Forces members and ex-Canadian Forces personnel showed that 15% of responders reported symptoms of posttraumatic stress

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104 23 February, 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

105 Veterans Affairs Canada, *2004-2005 Performance Report*, p. 10, http://www.tbs-sct.gc.ca/rma/dpr1/04-05/VAC-ACC/VAC-ACCd45_e.pdf.

106 23 February, 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

disorder but had never applied for a pension. Despite the potential under-application, he reported that:

> *We have more than 8,000 clients pensioned for mental health-related conditions. More than half of these clients suffer from PTSD alone, and the incidence among our younger CF members is increasing each year.*

13.4.2 Federal Programs and Services

13.4.2.1 Disability Pension Program

Pension entitlement depends on the nature of the claimant's service. For war, peacekeeping service and other special duty service, the relevant injury or disease must have been incurred during, or be attributable to, the claimant's service. For peacetime military and RCMP service, the claimed injury or disease must have arisen out of, or be directly connected with, the service. This leads to two different types of pension coverage as described by the Veterans Review and Appeal Board:

The disability pension is based on the severity of the disability, as verified by a medical examination, and is assessed in accordance with an established Table of Disabilities. This disability pension program has been the gateway to the health care benefits and other programs offered by Veterans Affairs Canada.

> The first, for war, peacekeeping and special duty service, is intended to provide 24 hour a day coverage and consequently is commonly referred to as the insurance principle. The second, for peacetime military and RCMP service, is known as the compensation principle. The coverage is meant to be similar to that provided under workers' compensation programs.[107]

Veterans Affairs Canada administers the *Pension Act* and through the Disability Pension Program provides disability pensions to those suffering from disabilities related to peace or wartime military service and to eligible RCMP members. The disability pension is based on the severity of the disability, as verified by a medical examination, and is assessed in accordance with an established Table of Disabilities.[108]

This disability pension program has been the gateway to the health care benefits and other programs offered by Veterans Affairs Canada, benefits and programs that were designed to meet the needs of traditional war service veterans rather than the present-day Canadian Forces members and veterans.

The New Veterans Charter — the *Canadian Forces Members and Veterans Re-establishment and Compensations Act* — has changed the process, however. Draft regulations published in December 2005 are more responsive to the needs of Canadian Forces members who are

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[107] Veterans Review and Appeal Board, *Annotated Pension Act*, 2005, http://www.vrab-tacra.gc.ca/Documents/AnnotatedAct-March2005.pdf.

[108] Veterans Affairs Canada, *2004-2005 Performance Report*, p. 17, http://www.tbs-sct.gc.ca/rma/dpr1/04-05/VAC-ACC/VAC-ACCd45_e.pdf.

released due to disability.[109] The regulations are targeted to fill gaps in programs and services for eligible members released for medical reasons and for members who voluntarily leave the Canadian Forces and then develop later a service-related disability.

The introduction to the draft regulations states:

> [T]he New Veterans Charter will bolster the current benefit packages provided by the Service Income Security Insurance Plan (SISIP) and VAC. Most CF members who voluntarily release and later develop a service-related disability could, up to now, only qualify for a VAC pension and related health care. SISIP will continue to provide eligible medically releasing CF members with income replacement and vocational rehabilitation benefits. Under the New Veterans Charter, VAC will meet the needs of the "gap" group and will provide top-up benefits for the SISIP group, such as additional vocational rehabilitation or earnings loss benefits, medical or psychosocial rehabilitation, and Canadian Forces income support.[110]

13.4.2.2 Health Benefits Program

It is expected that the proposed Health Benefits Program "will fill gaps in post-release health coverage by ensuring that medically released CF Veterans have access to group family health insurance."

At present, clients eligible for health care benefits or services are provided with a VAC Health Care Identification card that gives them access to providers across the country. Veterans Affairs Canada delivers a wide range of services and benefits covered under the mandates of the Treatment and Benefits, Long-term Care, and Veterans Independence Programs. These include:

- Community-based mental health care (including a comprehensive range of health care benefits not provided provincially) for war and Canadian Forces veterans who meet service and income requirements or who have been awarded disability pensions resulting from military service;
- Institutional mental health care (largely psycho-geriatric, including Alzheimer care) to eligible veterans in the departmental hospital at Ste-Anne-de-Bellevue, Quebec, in contract hospital beds located in provincial health care institutions and in hospitals of choice;
- General mental health care as well as care for posttraumatic stress disorder and operational stress, through services offered jointly with the Department of National Defence.

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[109] Government of Canada, *Canada Gazette,* "Canadian Forces Members and Veterans Re-establishment and Compensation Regulations," Vol. 139, No. 51, 17 December 2005, http://canadagazette.gc.ca/partI/2005/20051217/html/regle7-e.html.

[110] *Ibid.*, Service Income Security Insurance Plan (SISIP) is described in the previous Canadian Forces section 13.3.3.2.

The *Canadian Forces Members and Veterans Re-establishment and Compensation Act* authorized the Minister to "establish or enter into a contract to acquire a group health insurance program comparable to the Public Service Health Care Plan established by Treasury Board."[111] It is expected that the proposed Health Benefits Program "will fill gaps in post-release health coverage by ensuring that medically released CF Veterans (with some exceptions for reservists), CF Veterans with a 'rehabilitation need' and certain survivors who are currently ineligible for health coverage have access to group family health insurance."[112]

13.4.2.3 Joint Efforts on Mental Health

Some programs and services resulting from the joint VAC/DND mental health strategy announced in 2002 include:

- VAC assistance line in partnership with DND and Health Canada to provide telephone crisis counselling services for veterans and their families;
- joint DND/Veterans Affairs centre in Ottawa for the care of injured and released members veterans and families with assistance expedited through a 1-800 number;
- cross-Canada case worker system of VAC and DND for early identification of the transition needs of clients, including their needs for disability assistance;
- network of operational stress injury clinics across the country with St. Anne's Centre taking the clinical lead and others in London, Winnipeg, and Quebec City.[113]

The mental health strategy also includes continuing education to keep staff aware of changes to services and programs designed to meet changing client needs and ongoing research in the area of operational stress injuries in partnership with DND and others. The draft regulations of the *Canadian Forces Members and Veterans Re-establishment and Compensation Act* provide information on mental health care delivery, using multiple providers to:

> ... involve the use of multiple service providers from different agencies, organizations and private providers of service, with the delivery being coordinated under the direction of a case manager within VAC. For example, for a mental health problem, the medical

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111 *Canadian Forces Members and Veterans Re-establishment and Compensation Act*, 2005, c.21, http://laws.justice.gc.ca/en/C-16.8/index.html.

112 A "rehabilitation need" is a physical or mental health problem resulting primarily from service in the Canadian Forces that is creating a barrier to re-establishment in civilian life." Government of Canada, *Canada Gazette*, "Canadian Forces Members and Veterans Re-establishment and Compensation Regulations," Vol. 139, No. 51, 17 December 2005, http://canadagazette.gc.ca/partI/2005/20051217/html/regle7-e.html.

113 The National Mental Health Clinical Centre of Expertise at Ste-Anne de Bellevue is responsible for advances in mental health clinical care through program development, research, education and outreach; Veterans Affairs, *News Release,* "National Mental Health Clinical Centre of Expertise Officially Opens," 7 November 2005, http://news.gc.ca/cfmx/view/en/index.jsp?articleid=181199&.

> rehabilitation phase could involve the family physician, a hospital-based psychiatrist, a community mental health team or a VAC-supported private sector therapist. A psychosocial phase may involve an occupational therapist or pain management clinic, and a vocational phase may involve specialized assessment services and training providers.[114]

On posttraumatic stress disorder and other operational stress injuries, there is ongoing work within the military structure and the civilian medical community. In particular, Veterans Affairs Canada supports the Operational Stress Injury Social Peer Support Program established by DND:

> *The peer support program is made up of Canadian forces members and veterans across the country who have experienced an operational stress injury themselves, and who want to help others heal and recover. DND has established 13 peer support coordinators located across the country and to date they have helped more than 1400 clients. This network uses a large number of volunteers and we have a brochure we will circulate to the members that shows some of the work volunteers do in helping with these peer support coordinators.*
> *—Brian Ferguson*[115]

13.4.3 Assessments of Client Group Needs

Veterans with mental health concerns constitute a diverse group needing a range of re-establishment programs: transition assistance; job-finding help; rehabilitation; retraining; income support; health care; family assistance; and other elements that encourage independence.

Veterans with mental health concerns constitute a diverse group needing a range of re-establishment programs: transition assistance; job-finding help; rehabilitation; retraining; income support; health care; family assistance; and other elements that encourage independence.

13.4.3.1 Disability Pensions

According to Brian Ferguson, Veterans Affairs Canada aims to provide the same basic approach for aging veterans and for younger veterans with mental health problems:

Former or current peacetime members of the Canadian Forces, reported dissatisfaction with the process for accessing pensions.

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[114] Government of Canada, *Canada Gazette*, "Canadian Forces Members and Veterans Re-establishment and Compensation Regulations," Vol. 139, No. 51, 17 December 2005, http://canadagazette.gc.ca/partI/2005/20051217/html/regle7-e.html.

[115] 23 February, 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

> *If they have a pension condition and they require treatment, we pay for it; and we keep track of the treatments that are made on their behalf.*[116]

However, former or current peacetime members of the Canadian Forces, who, together with survivors and the dependents of military personnel, now form a larger group of disability pension recipients than war service veterans, reported dissatisfaction with the process for accessing pensions. An audit of the Disability Pension Program conducted in 2005 reported that CF clients felt that there was:

> ... insufficient understanding of the DND culture, including the command structure, and the physical, mental, and emotional stress of military training and deployment to hazardous overseas operating environments.[117]

At present, the Veterans Review and Appeal Board provides two levels of appeal on disability pension applications as well as a final level of appeal on allowance decisions. In the period between April 2004 and March 2005, the Board heard 6789 claims.[118] Clients and other observers noted difficulties in assessing mental disability claims when criteria and standards are not clear and objective. They noted that reporting and record-keeping during periods of conflict may be a low priority, especially for non-life threatening incidents that could have an effect on mental health.

In June 2005, the Esprit de Corps magazine issued a press release calling for a Veterans Affairs Canada Ombudsman, similar to the one for the CF, noting that:

The irony is that healthy, (for the most part) employable soldiers in DND have an independent ombudsman while disabled and often unemployable veterans do not.

> The irony is that healthy, (for the most part) employable soldiers in DND have an independent ombudsman while disabled and often unemployable veterans do not.

The press release went on to point out the complexities of current disabilities and the resulting low pension awards:

> Minimal awards of 20% or $400/month have been quite common for disabilities that have rendered a veteran unemployable. As a consequence, psychologically and/or physically disabled veterans are forced to enter an indescribably demoralizing review and appeal

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116 23 February, 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

117 Veterans Affairs Canada, *Volume II of the Disability Pension Program Evaluation,* July 2005, http://www.vac-acc.gc.ca/general/sub.cfm?source=department/reports/deptaudrep/disapen_eval_july2005.

118 Veterans Review and Appeal Board, "About Veterans Review and Appeal Board," http://www.vrab-tacra.gc.ca/AboutVRAB.htm.

process, frequently requiring three to five years or more before receiving adequate compensation.[119]

13.4.3.2 Case Management

Case management services could help clients and their families cope with psychological disability and work their way through a complex landscape of programs.

The case management approach implemented by Veterans Affairs Canada permits the department to track the development of each client's illness. The goal is to simplify access to existing programs and provide adequate case management services, especially for those who are medically released and often need the most help getting re-established in civilian life. The hope is that case managers will be able to assist people in navigating the maze of providers and benefits that might include Veterans Affairs, National Defence, the Service Income Security Insurance Plan, the Department of Social Development, the Canada Pension Plan disability pension program, the applicable provincial/territorial health care system, and local social assistance avenues.

> The list of potential service providers is lengthy, the inter-relationship between different programs is complex, and the choices to be made are not always clear. Sometimes, winning benefits from one program results in benefits being clawed back from another. This is administratively cumbersome and gets in the way of best service.[120]

Mr. Ferguson noted how a case manager could simplify the situation facing a client dealing with the loss of income and career. Case management services could help clients and their families cope with psychological disability and work their way through a complex landscape of programs:

> *A forty-year-old male veteran was pensioned 80% for PTSD related to his service in his special duty area. He is suicidal at times and his wife and children have left home in fear for their own safety. After being discharged from his local hospital, he was faced with a lack of medical resources to help him in his time of need, a familiar refrain. He called Veterans Affairs Canada and spoke to an area counsellor who worked with his local district office staff to explore options. We had to make arrangements with our partners in the United States to get him treatment, but then a local opportunity presented itself. Through our partnerships with DND and local medical practitioners, we were able to get him treatment at the local DND Operational, Trauma and Stress Support Centre, OTSSC. This client will be assisted through case*

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[119] Ombudsman Ontario, "The Case for a VAC Ombudsman — Esprit de Corps," July 2005, http://www.ombudsman.on.ca/PR_details.asp?PRID=174.

[120] Veterans Affairs Canada- Canadian Forces Advisory Council, *Honouring Canada's Commitment Opportunity with Security for Canadian Forces Veterans and their Families in the 21st Century*, March 2004, http://www.vac-acc.gc.ca/clients/sub.cfm?source=councils/vaccfac/committment.

management services at the local Veterans Affairs Canada district office to maintain contact with his clinical service providers.[121]

13.4.3.3 Service Provision

Veterans Affairs Canada has difficulties accessing mental health services through provincial providers.

Veterans Affairs Canada, like other federal departments with clients experiencing mental health problems, has difficulties accessing mental health services through provincial providers. Mr. Ferguson explained that it is trying to adopt an approach of early intervention to keep mental health situations from growing more serious:

> *Currently VAC, like DND, must compete for scarce acute psychiatric services along with other Canadian citizens. For this reason, we are putting our emphasis on early detection and intervention to detect problems early and prevent acute crisis situations from escalating. Our district office health professionals can intervene on behalf of clients to assist them in receiving the appropriate acute care and monitor their progress after the acute phase.*[122]

Telehealth is one option that shows promise for the department and its clients.

Telehealth is one option that shows promise for the department and its clients. Veterans Affairs Canada, in cooperation with the Memorial University School of Medicine in Newfoundland, is using video-conferencing technology to link clients with professional psychological counselling experts.[123]

Dr. Ted Callanan, President, Psychiatric Association of Newfoundland and Labrador, commented on the Veterans' Affairs Canada peer support program and treatment program for those suffering from posttraumatic stress disorders or other conditions related to military service. He noted that, while some choose to come to St. John's where most of the services are located, telehealth has provided options for those living in other areas of the province:

> *... they can also access their counsellors via telehealth technology now and that is actually proving to be fairly popular. They have worked out some ways around identifying why the different individuals would be coming to the telehealth centre in the small towns and that is moving now into Nova Scotia and going across the country, not as a replacement, but as another means of veterans accessing service.*

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121 23 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

122 23 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

123 Veterans Affairs Canada, *Support for the CF Community*, http://www.vac-acc.gc.ca/clients/sub.cfm?source=salute/osi_edition/cf_support.

13.4.4 Committee Commentary

The Committee is supportive of efforts to overhaul the way that mental health of veterans is assessed and injured veterans are compensated. It commends the increased efforts directed at partnering and the greater coordination of activities between VAC and DND. The establishment of a strong network between the two departments will encourage improvements of services for CF members as well as other clients.

The Committee is supportive of efforts to overhaul the way that mental health of veterans is assessed and injured veterans are compensated. It commends the increased efforts directed at partnering and the greater coordination of activities between VAC and DND.

As with other federal client groups, the Committee is concerned that Parliament may not be aware of the full extent of efforts to assist transition to civilian life and to give disabled veterans a high quality of life.

The Committee therefore recommends:

78	**That Veterans Affairs Canada in conjunction with National Defence prepare an annual inventory of programs and services for mental health, including the number of clients served, the funding allocated and spent, and the outcomes achieved.** **That the report be tabled in Parliament annually starting in 2008.**

The Committee is concerned that there is no forum for veterans similar to the Canadian Forces Ombudsman. It sees merit in having an independent and objective body to review and make recommendations on concerns of veterans.

The Committee is concerned that there is no forum for veterans similar to the Canadian Forces Ombudsman. It sees merit in having an independent and objective body to review and make recommendations on concerns of veterans.

The Committee recommends:

79	**That the Government of Canada establish an entity for veterans, similar to the Correctional Investigator, the Canadian Forces Ombudsman, or the RCMP External Review Committee;** **That this entity be authorized to investigate individual complaints as well as systemic areas of concern related to federal provision of programs and services that have an impact on the mental wellbeing of veterans;** **That this entity provide an annual report to Parliament.**

13.5 ROYAL CANADIAN MOUNTED POLICE

> *... traditional policing practices do not work in the way they are meant to work in dealing with people who are in a mental health crisis.*
> *—Shirley Heafey, Chair of the RCMP Public Complaints' Commission*[124]

13.5.1 Federal Responsibility

Under the *Canada Health Act*, "a member of the Royal Canadian Mounted Police who is appointed to a rank" is excluded from the definition of "insured persons." The Royal Canadian Mounted Police is organized under the authority of the *Royal Canadian Mounted Police Act*,[125] which sets out the qualifications required for being a member of the RCMP. The *Royal Canadian Mounted Police Regulations* outline the basic conditions for regular members or special constable members to have access to health services, subject to approval by the Commissioner.[126] As of 31 March 2005, the Force had 22,557 employees, including regular and civilian members and public service employees.[127]

The *Royal Canadian Mounted Police Regulations* contain several specific provisions that deal with mental health issues as a disability, although they do not distinguish between an incapacity that is work-related and one that is not. With respect to administrative discharges, "a member, other than an officer, may be discharged from the Force, and it may be recommended that an officer be discharged from the Force, on any of the following grounds, namely, (*a*) physical or mental disability after consideration by a medical board."

Royal Canadian Mounted Police members who have become disabled as the result of Special Duty Service,[128] and who have consequently been released or discharged from the RCMP are entitled to be appointed ahead of others to positions in the public service for which they are qualified.[129] Also, after discharge or compulsory retirement, the *Royal Canadian Mounted Police Superannuation Act* specifies that a recipient of supplementary benefits can be

> a person who, not having reached sixty years of age, is in receipt of a pension as a result of having been compulsorily retired from the

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124 10 May 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/15evc-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

125 *Royal Canadian Mounted Police Act*, R.S. 1985, c. R-10, http://laws.justice.gc.ca/en/R-10/index.html.

126 *Royal Canadian Mounted Police Regulations*, 1988 (SOR/88-361) http://laws.justice.gc.ca/en/R-10/SOR-88-361/174146.html.

127 Royal Canadian Mounted Police, *Departmental Performance Report for the period ending March 31, 2005*, p. 23, http://www.tbs-sct.gc.ca/rma/dpr1/04-05/RCMP-GRC/RCMP-GRCd4502_e.asp#glance.

128 Special Duty Service involves designated operations which could include armed conflict, peacekeeping missions, anti-terrorism activities, disaster relief or search and rescue activities.

129 Public Service Commission, *Guide to the Priority for Members of the CF and RCMP who become Disabled*, http://www.psc-cfp.gc.ca/staf_dot/priority-priorite/rcmp-grc_e.htm.

> Force by reason of any mental or physical condition rendering the person disabled,[130]

In 2003 Veterans Affairs Canada undertook responsibility for administering the RCMP disability pension and health care benefits for RCMP members who are pensioned for service-related injuries and illnesses. It assumed responsibility for the direct payment of disability pensions for approximately 3,800 RCMP pensioners as well as the provision of health care benefits for approximately 800 retired and civilian pensioners.[131] By early 2005, it was estimated that VAC delivered benefits and services to more than 5,000 RCMP clients, including 300 pensionable survivors of RCMP members.[132]

13.5.2 Federal Programs and Services

The RCMP External Review Committee was established in 1988 to provide impartial reviews of certain grievances as well as appeals relating to formal disciplinary measures. Upon completing its review of a case, the External Review Committee presents recommendations to the Commissioner of the RCMP, who is the final decision-maker, but who must provide reasons if he disagrees with the Committee in any given case.

Various reports of the External Review Committee yielded information about the mental health, mental illness and addiction concerns of RCMP members, including increased sick time, impaired work performance, and alcohol dependency as outcomes associated with increased stressors for RCMP members.[133] In some cases of dismissal for conduct deemed disgraceful that were reviewed by the RCMP External Review Committee, stress-related incidents led to recommendations ranging from orders to voluntarily resign or be dismissed to medical discharge on grounds of mental disability.

Lack of training in dealing with public manifestations of mental illness is also endemic to the internal workings of the RCMP.

The judge stated that RCMP training to deal with mentally ill people varied from non-existent to less than adequate.

— *Shirley Heafey*

Several witnesses spoke to the Committee about the lack of sensitivity exhibited by RCMP officers dealing with mentally ill individuals in the community. They also suggested that lack of training in dealing with public manifestations of mental illness is also endemic to the internal workings of the RCMP. In this regard, Shirley Heafey, Chair of the RCMP Public Complaints' Commission told the Committee:

> *In 2003, during the course of a judicial inquiry into the RCMP shooting death of a person in a mental health crisis, the judge stated that RCMP*

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130 *Royal Canadian Mounted Police Superannuation Act*, R.S. 1985, c. R-11, http://laws.justice.gc.ca/en/R-11/text.html.

131 Royal Canadian Mounted Police, "Veterans Affairs Canada and the Royal Canadian Mounted Police Partner to Improve Services," *RCMP News Release*, 17 February 2003.

132 RCMP, "The New Veterans Charter — Chief Human Resource Officers Message," 24 May 2005, http://www.rcmp.ca/vets/new_charter_e.htm#top.

133 Royal Canadian Mounted Police External Review Committee, Publications, including research reports and communiqués about individual cases, http://www.erc-cee.gc.ca/english/publications_date.html.

> *training to deal with mentally ill people varied from non-existent to less than adequate, and that all three RCMP incident officers welcomed the idea of more and better training in this area.*[134]

Doris Ray told the Committee of her experience as a family member:

> *The officer confided that he had learned about the symptoms of schizophrenia through his brother-in-law who suffered from the disease. His training in the RCMP, most often the first line of defence for families in crisis situations, especially in small towns, included very little training in recognizing and dealing with symptoms of psychosis. I recently inquired of a young officer if he had had any more training in that line and he said they now receive even less training than in years past.*[135]

In general, the RCMP provides comprehensive health services to ensure that regular members are emotionally and medically fit to perform their duties. Should a serving member of the RCMP use services provided by a given province, they present their client registration number which ensures that authorization is obtained from an RCMP Health Services Officer; the provincial service then bills the RCMP. Each RCMP division usually has a physician as regional health services officer, together with a regional psychologist and a variable number of occupational health nurses.

A study in 1992 identified three general sources of occupationally-linked police stress that can lead to such common mental health symptoms as depression, burnout and suicide:[136]

Police officers may be hampered by a belief that admitting to problems and seeking help suggests weakness.

- external stressors linked to factors such as court appearances, cross-examinations, lengthy judicial decisions, lack of encouragement from the public, relations with minority groups and the general mass-media image of police;
- internal stressors related to police organization and structure such as lack of participation in work organization, communication problems, insufficient support from superiors, and excessive bureaucracy, training, performance evaluation, salary, promotion, inadequate human and material resources; and
- task-related stressors such as work overload alternating with periods of inactivity, role conflicts and ambiguities, perception of danger, task complexity, lack of autonomy, ambiguous feelings and the responsibility of facing misery, pain and death.

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134 10 May 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/15evc-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

135 6 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/18eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

136 Royal Canadian Mounted Police External Review Committee, *Occupational Health and Safety- An Employer Perspective*, Discussion Paper 9, 1992, http://www.erc-cee.gc.ca/Discussion/english/eDP9.htm.

This study revealed a relationship between occupational stressors and reductions in productivity, increases in reaction time and judgement errors, work dissatisfaction, the desire to quit, absenteeism and accidents.[137] Another report on Employee Assistance Programs emphasized the difficulty in implementing assistance programs in the policing sector where police departments operate as a "closed society." Also, police officers may be hampered by a belief that admitting to problems and seeking help suggests weakness.[138]

When the RCMP recruit psychologists, they try to hire them at "$20- to $30,000 less than what the hospital down the street is paying."

Services available to RCMP officers through the RCMP Health Services are variable. Health services officers generally act as case managers — providing assessment, referral and follow-up for such things as treatment and rehabilitation programs for substance abuse and related personal problems.[139] Dorothy Cotton, Co-chair/Psychologist, Canadian National Committee for Police/Mental Health Liaison, pointed out that when the RCMP recruit psychologists, they try to hire them at "$20- to $30,000 less than what the hospital down the street is paying." She insisted that "you cannot hire people for that kind of money. It also speaks to what they think of the profession."[140]

13.5.3 Assessments of Client Group Needs

The RCMP recently announced its recognition as one of the country's top employers in the 2006 edition of *Canada's Top 100 Employers*.[141] Its own surveys of performance in 2003-2004, however, identified problems with morale, work environment, communications, tools and training, workload, responsibility and support systems. The survey reported "overall employee satisfaction: 61%; although employees are proud of our organization and the work they do, there were numerous issues regarding workload, fairness and career development."[142]

The RCMP was not included in the New Veterans Charter and thus was excluded from the proposals for change to Veterans Affairs Canada programs and services aimed at CF clients.

In 2002, Norman Sabourin, Executive Director and Senior Counsel for the External Review Committee, wrote an article titled "Medical Discharge and the Duty to accommodate in the RCMP." In his conclusion, he argued that "the Force will have to find a suitable position for

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137 *Ibid.*

138 Royal Canadian Mounted Police External Review Committee, *Employee Assistance Programs — Philosophy, theory and practice,* Discussion Paper 5, 1990, http://www.erc-cee.gc.ca/Discussion/english/eDP5.htm.

139 Health Canada, *Profile — Substance Abuse Treatment & Rehabilitation in Canada*, "The federal role in substance abuse treatment," 1999, http://www.hc-sc.gc.ca/ahc-asc/pubs/drugs-drogues/profile-profil/federal_e.html.

140 16 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/06eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

141 RCMP, *News Release*, "RCMP Named One of Canada's Top 100 Employers," 18 October 2005, http://www.rcmp-grc.gc.ca/news/n_0524_e.htm.

142 RCMP, *Departmental Performance Report 2003-2004*, http://www.tbs-sct.gc.ca/rma/dpr/03-04/RCMP-GRC/RCMP-GRCd3401_e.asp#Lines.

a member with an impairment who wishes to continue working, or else demonstrate that it would face undue hardship by doing so." He emphasized that "this will require significant changes to existing policies."[143]

For RCMP members, there is a disparity between the disability services and benefits available to them and those available to other clients served by Veterans Affairs Canada. For example, the RCMP do not have access to the Veterans Independence Program services (home care, home adaptations, transportation, ambulatory health care and nursing home care). Veterans Affairs Canada indicated that it is prepared to consider ways of addressing some of the gaps in services:

> To date, research undertaken in collaboration with the RCMP reveals that, while not necessarily sharing the same views, attitudes and mind-set as CF clients, the RCMP understand and appear to relate well to CF issues and concerns. This is, no doubt, linked to both groups having worked in/been exposed to similar situations and environments, including peacekeeping/SDA deployments. In order to adequately address gaps in services/benefits, training will be required for VAC staff to increase their general understanding of the RCMP and the 'police' culture.[144]

However, the RCMP was not included in the New Veterans Charter and thus was excluded from the proposals for change to Veterans Affairs Canada programs and services aimed at CF clients. Instead, the RCMP indicated that it would do its own assessment of needs:

> The RCMP has opted to conduct an assessment of its still-serving and retired members' needs for modernized services and programs. This assessment is necessary as there are considerable differences in the profiles, roles, career paths and qualifications of today's RCMP and CF members. Consequently, the needs of RCMP members may be quite different than those of CF members.[145]

Several RCMP veterans' associations reported on correspondence from the RCMP Commissioner stating that a Task Force on the Modernization of Disability Programs and Services had been established to oversee a comprehensive needs analysis. The assessment was to look at both the service by RCMP under the *Pension Act* and the access to long term care and in-home independence benefits (Veterans Independence Program) that go beyond those available in the Attendance Allowance.[146] Claiming other priorities, the RCMP had already delayed this needs analysis from previous years and, although expected to be reported in the fall of 2005, it was not available to the public by early 2006.

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143 Norman Sabourin, "Medical Dischage and Duty to Accommodate in the RCMP," External Review Committee, March 2002,http://www.erc-cee.gc.ca/english/articles/articles_medicaldischarge.html.

144 Veterans Affairs Canada, *Putting Our Priorities into Action, Five year Strategic Plan — Update 2004*, http://www.vac-acc.gc.ca/general/sub.cfm?source=department/reports/update2004/action04.

145 RCMP, "The New Veterans Charter — Chief Human Resource Officers Message," 24 May 2005, http://www.rcmp.ca/vets/new_charter_e.htm#top.

146 RCMP Veteran's Association, Calgary Division, "Notes of Interest," http://www.members.shaw.ca/rcmpvets.calgary/notes.htm.

13.5.4 Committee Commentary

The Committee is unaware of the training provided to RCMP officers to increase their understanding of mental illness.

The Committee is aware of the efforts by the RCMP to address the needs of its officers who pursue disability claims, some of them related to mental health issues. Nevertheless, more readily available public information on this federal client group is needed.

The Committee wants to know if the RCMP provides counselling to employees after a traumatic situation or to them and their families during and after a stressful relocation. It is also interested in ways to address the particular transition needs of RCMP members who are being discharged and determine what adjustments may be required to legislation, health care policies and programs, and service delivery mechanisms to ensure their appropriate access to services.

The Committee wants to know if the RCMP provides counselling to employees after a traumatic situation or to them and their families during and after a stressful relocation. It is also interested in ways to address the particular transition needs of RCMP members who are being discharged and determine what adjustments may be required to legislation, health care policies and programs, and service delivery mechanisms to ensure their appropriate access to services.

In addition, the Committee is unaware of the training provided to RCMP officers to increase their understanding of mental illness. Witnesses suggest that it is limited or non-existent. Incorporating training about mental health and addictions can enhance not only officers' ability to deal with the public but also their ability to understand facets of mental illness among their colleagues within the Force itself.

The Committee recommends:

80	**That the federal government fund a mental health and addictions training program aimed at RCMP members.** **That the RCMP make public as soon as possible in 2006 the results of the ongoing analysis by the RCMP task force looking at RCMP disability and the need for programs and services.** **That the RCMP establish the use of peer counselling for RCMP members following the DND/VAC model for post-traumatic stress.** **That the RCMP include these initiatives and other programs and services in an annual inventory on programs and services for RCMP officers.** **That the inventory be reported to Parliament annually starting in 2008.**

The Committee is pleased that the RCMP has established an External Review Committee to undertake investigations into specific issues. This body appears to be well-placed to conduct more analysis of the mental health needs of RCMP members.

The Committee recommends:

81	**That the RCMP External Review Committee do an analysis of the mental health needs of RCMP members and RCMP veterans and report to Parliament by 2007.**

13.6 IMMIGRANTS AND REFUGEES

> *The mental health system recognizes the need to address posttraumatic syndrome, but fails to recognize that, until racism is addressed, which is the trauma refugees and new immigrants experience on a daily basis, such an approach will be ineffective. —Martha Ocampo, Co-Director, Across Boundaries, Ethnoracial Mental Health Centre, Toronto*[147]

13.6.1 Federal Responsibility

Citizenship and Immigration Canada (CIC) is responsible for the admission into Canada of immigrants, foreign students, visitors, temporary workers and refugees. As described by Dr. Sylvie Martin, Acting Director, Immigration Health Program Elaboration, Medical Services Branch, Citizenship and Immigration Canada.

All applicants for permanent residence and some for temporary residence (e.g. visitors, students and workers) undergo a physical and mental examination.

> *Under the Immigration and Refugee Protection Act and its regulations, the department admits temporary residents and immigrants who contribute to the economic and social growth of Canada, it provides resettlement, protection and a safe haven to refugees, it assists newcomers to adapt to Canadian society and eventually obtain citizenship, and it manages access to Canada in order to protect the security and health of Canadians as well as the integrity of Canadian laws.*[148]

Under the *Immigration and Refugee Protection Act*, all applicants for permanent residence and some for temporary residence (e.g. visitors, students and workers) undergo a physical and mental examination.[149] Based on this examination, applicants may be refused entry into Canada if they have a physical or mental health condition that is considered likely to be a danger to public health or safety, or that could be very demanding on health or social services. Information from the Department is not specific about possible responses to applicants who are living with mental disorders.

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147 17 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/07ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

148 23 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

149 *Immigration and Refugee Protection Act*, 2001, c. 27, http://laws.justice.gc.ca/en/I-2.5/.

The term, "excessive demand," refers to "the burden placed on Canada's health or social services due to ongoing hospitalization or medical, social or institutional care for physical or mental illnesses, or special education or training."[150] To determine if an applicant will likely create such excessive demand, a departmentally-designated Medical Officer will consider the diagnosis, prognosis, and the health and/or social service needs of the individual concerned over a period of time (usually five years). The Medical Officer will then assess the anticipated costs of these needs over a five year period *and* determine if there are waiting lists for any of the necessary services. If the anticipated costs exceed the average Canadian's per capita health and social services costs over five years, of if there are waiting lists for any of the necessary services, the applicant will be deemed inadmissible.[151] Certain groups defined in section 38(2) of the *Immigration and Refugee Protection Act* receive an "excessive demand exemption" and will not be refused entry based on possible health demands.[152]

After admission to Canada, the expectation is that the delivery of programs and services related to mental health that fall into the public health care sphere will be a responsibility of the provinces and territories.

After admission to Canada, the expectation is that the delivery of programs and services related to mental health that fall into the public health care sphere will be a responsibility of the provinces and territories. This is dependent, however, on variables such as the length of time it takes for federal processing of a claimant's application and the nature of the agreement between the federal government and a province or territory with respect to settlement and integration services. Landed immigrants are expected (but do not always manage) to arrange their own health care, including private insurance to cover the 3 month waiting period for coverage imposed in four provinces (British Columbia, Ontario, Quebec and New Brunswick).[153]

In the department's 2005 performance report to Parliament, Citizenship and Immigration Canada indicated that a total of 235,824 people were admitted to Canada as permanent residents in 2004.[(154)] Of the newcomers admitted, the department noted that:

- 57% (133,746) were economic immigrants and their dependants;

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150 Citizenship and Immigration Canada, *Applying for Permanent Residence,* "Appendix D: Medical Examinations," 2004, http://www.cic.gc.ca/ENGLISH/pdf/kits/guides/4000E.PDF.

151 Correspondence from Dr. Sylvie Martin, Acting Director, Immigration Health Program Elaboration, Medical Services Branch, Citizenship and Immigration Canada to Senator Michael Kirby, Chair, Standing Committee on Social Affairs, Science and Technology, The Senate, 3 February 2006.

152 Family class sponsored spouses, common-law partners, conjugal partners and their dependent children, and convention refugees and persons in need of protection and their dependents, will not be refused entry if they have a health condition that places excessive demand on health or social services; CIC, *Medical Testing and Surveillance*, Fact Sheet 20, http://www.cic.gc.ca/english/irpa/fs%2Dmedical.html.

153 Anita Gagnon, *Responsiveness of the Canadian Health Care System Toward Newcomers*, Discussion Paper no.40, Commission on the Future of Health Care in Canada, November 2002, http://www.hc-sc.gc.ca/english/pdf/romanow/pdfs/40_Gagnon_E.pdf.

154 Citizenship and Immigration Canada, *Departmental Performance Report for the period ending March 31, 2005*, p. 61, http://www.tbs-sct.gc.ca/rma/dpr1/04-05/CI-CI/CI-CId45_e.pdf.

- 26% (62,246) were in the family class;
- 14% (32,685) were refugees and other protected persons;
- 3% (6,945) were granted permanent resident status on humanitarian and compassionate grounds.

13.6.2 Federal Programs and Services

13.6.2.1 Interim Federal Health Program

Citizenship and Immigration Canada's direct role in the provision of mental health services is through the Interim Federal Health Program. This program originated with a 1957 Order-in-Council and was moved from Health Canada to Citizenship and Immigration Canada in 1995. As Dr. Martin indicated:

> *... it offers health services to migrants, currently refugee claimants, refugees, detainees in immigration detention centres and failed refugees still in Canada who are unable to pay for their health care services. It covers essential and emergency medical services, including mental health services such as consultation with physician, hospitalization and essential medication. The overall budget for this program was $51 million in 2002-2003, with 97,000 users and 700,000 claims.*[155]

Citizenship and Immigration Canada's direct role in the provision of mental health services is through the Interim Federal Health Program.

The program is administered by FAS (Funds Administrative Service Inc.) Benefit Administrators in Edmonton. Mental health services covered under the Interim Federal Health Program are limited but do include: consultations with a psychiatrist, hospitalization for psychiatric disorders, initial psychotherapy session with a physician (follow up covered if approved) and essential medication.

The department did not provide a breakdown of expenditures that relate to mental illness or addiction. It is reasonable to assume, however, that these could be significant, given that many refugee claimants have been victims of torture and have endured other strains on their mental health.

Some provinces have raised concerns about the adequacy of the Interim Federal Health program to meet the overall costs of immigration-related medical and health services. They have asked for reviews of levels of permitted fees, scope of covered services, and reimbursement of provincial costs incurred for service provision. For example, the 2004 British Columbia accord authorized under the *Immigration and Refugee Protection Act* points to the need for consideration of provincial costs incurred in providing services for refugee claimants; for immigrants deemed to be medically inadmissible who are allowed to proceed to Canada under new legislation (excessive demand exemption), and for people admitted

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[155] 23 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

with serious health problems during the three (3) month waiting period for British Columbia's Medical Services Plan coverage.[156]

13.6.2.2 Other Initiatives

Dr. Martin pointed out that the department also has other initiatives designed to contribute positively to the mental health of newcomers to Canada:

> *If mental health is defined as each person's ability to experience, reflect and act in such a way as to obtain the greatest enjoyment from life and to cope with different challenges, it can be said that Citizenship and Immigration Canada is responsible for a number of initiatives that are either directly or indirectly linked to mental health.*
>
> *Several of our programs are aimed at facilitating and improving the social, cultural and economic integration of newcomers, thus reducing the stress involved in settling in a new country for the benefit of such newcomers.*
>
> *These different programs provide information relating to existing resources and facilitate the access to such services.*[157]

Citizenship and Immigration Canada attempts to ease the stress of integrating into Canadian society through several programs:

- The Immigrant Settlement and Adaptation Program funds service provider organizations to provide counselling and non-therapeutic services to newcomers, including referrals to services for educational, legal, social and health needs as well as employment and housing.

- The Host Program funds the recruitment, training, matching and coordination of volunteers who can help newcomers to deal with educational and health issues and to learn about and access available services in their community.

- The Resettlement Assistance Program provides income support and a range of immediate services. For the regular stream of government-assisted refugees, the department provides up to 12 months of income support; for those with special needs, this can be extended to 24 months. The amounts are guided by provincial social assistance rates.

Citizenship and Immigration Canada is also involved in other partnership arrangements at different levels. For example, it supports the Canadian Centre for Victims of Torture and the Metropolis project, a national/international forum for research and policy on migration. In addition, the F/P/T Working Group on Settlement and Integration discusses issues of a

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[156] Citizenship and Immigration Canada, *Agreement for Canada-British Columbia Cooperation on Immigration*, "Annex H — Immigration Health," http://www.cic.gc.ca/english/policy/fed-prov/bc-2004-annex-h.html.

[157] 23 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

multilateral nature. Interdepartmentally, there are joint initiatives with the Public Health Agency of Canada on migration health challenges, as well as with Industry Canada, Human Resources and Skills Development Canada and Health Canada on informational projects to facilitate integration.

Citizenship and Immigration Canada is also responsible for various linguistic programs including the Language Instruction for Newcomers to Canada Program that provides basic language instruction to adult immigrants to help them integrate successfully.

13.6.3 Assessments of Client Group Needs

Individuals who enter Canada as immigrants and refugees constitute a heterogeneous group. Some come to this country under an economic or a family category, some as refugees and others as asylum seekers. Some arrive having already received permission to live in Canada permanently while others arrive requesting acceptance as refugees. Regardless of the category, immigrants and refugees are newcomers to Canada carrying multiple experiences that shape how they will adapt to their new country.

In many towns, no language program or support services exist for immigrants, leaving them without access to resources that would enhance their mental health.

Even when people take language classes, they are not necessarily able to communicate their mental health needs, especially since language education is often geared primarily to individuals destined for the labour market.

Sister Mangalam Lena, a Franciscan Nun from Ottawa, spoke to the Committee on behalf of immigrants and refugees. Sister Lena, who is also a hospital chaplain and nurse as well as being a home-based spiritual care provider, talked of the many factors such as "loneliness" and "uprootedness," "woundedness" and "brokenness," that can affect a person's mental health. She described a program, initiated by immigrants themselves, that allows them to share their stories one-on-one. She explained:

> *Journeying with these immigrants, we know that many of them from these war countries have seen atrocities, they have seen their loved ones being killed and they have seen their mothers and sisters raped. In this new program, we see how creating a safe environment has brought them peace of mind and comfort.*[158]

The separation from family and community, combined with the inability to speak English or French, can contribute not only to serious emotional distress but also to reduced access to needed services. Although language programs may be in place, not everyone has access to them.

Over time, the underutilization of services by newcomers could prove very costly to the health care system.

In many towns, no language program or support services exist for immigrants, leaving them without access to resources that would enhance their mental health. Moreover, even when people take language classes, they are not necessarily able to communicate their mental

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[158] 21 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/23eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

health needs, especially since language education is often geared primarily to individuals destined for the labour market.

Raymond Chung, Executive Director, Hong Fook Mental Health Association, Toronto called for mandatory guidelines to be made available as required on the funding, training and service delivery model of trained mental health interpreters.[159] He stressed that, over time, the underutilization of services by newcomers could prove very costly to the health care system:

> *It is only through ethnocultural, language-specific mental health prevention and promotion strategies that we can achieve the goal of early identification and early intervention. In turn, you will help to reduce the financial and human costs in our society and, in the long run, for treating more serious mental illnesses.*[160]

Others witnesses observed how certain individuals, especially elderly persons and women from traditional cultures, are also more likely to experience difficulties during resettlement. Steve Lurie, Executive Director of the Canadian Mental Health Association, Toronto, pointed out that immigrant women with mental health problems need particular attention.[161]

Robena Sirett, Manager, Older Persons Adult Mental Health Services, Vancouver, indicated that there are knowledge gaps about the elderly victims of trauma or torture who come to Canada as refugees.

> *We are trying to develop programs that can be more responsive and flexible, depending on the refugees that are coming to our city…we did not have that cross-cultural competence where we could go in and work with them.*[162]

Racism may be one reason why eligible immigrants and refugees underutilize health services. Underutilization may be also result from fear that using mental health services could jeopardize ongoing immigration applications. As well, language barriers, experiences with culturally inappropriate care, or difficulties in navigating the health system can discourage people from using the services that are available.[163]

Underutilization may be also result from fear that using mental health services could jeopardize ongoing immigration applications.

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159 17 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/07ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

160 17 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/07ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

161 17 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/07ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

162 8 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/20ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

163 Anita Gagnon, *Responsiveness of the Canadian Health Care System Toward Newcomers*, Discussion Paper no.40, Commission on the Future of Health Care in Canada, November 2002, http://www.hc-sc.gc.ca/english/pdf/romanow/pdfs/40_Gagnon_E.pdf.

Martha Ocampo emphasised how the overall mental as well as physical health of newcomers, as for other Canadians, is strongly influenced by their social environment. Racism in combination with poverty, unemployment, inadequate housing and limited community support can all affect their successful integration, as can their relationship with those providing mental health services. Ms. Ocampo told the Committee:

> *The mental health of members from racialized communities cannot be understood in isolation from the social conditions of their lives. These conditions are characterized by social inequities which influence the type of mental health problems people from these communities develop and impact on how these problems are understood and treated by health professionals and the mental health system.*[164]

For Ms. Ocampo, the key to full participation is accommodation:

> *... you must remember that new immigrants or refugees are trying to settle and will need certain accommodations in order for them to participate fully. If the issue is child care or transportation expenses, there are many things that you have to consider.*[165]

13.6.4 Committee Commentary

The Committee acknowledges that Canada is regarded as a safe refuge for many of the increasing number of immigrants and refugees seeking to enter the country. But Canada's commitment to provide this safe refuge *must* include assurances that individuals have access to health services to help them deal with any mental health issues they face.

Canada's commitment to provide this safe refuge *must* include assurances that individuals have access to health services to help them deal with any mental health issues they face.

As with other federal client groups, the Committee has identified a role for an external body to provide oversight and assessment of how well the federal government is meeting its commitments to immigrants and refugees.

Thus, the Committee recommends:

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164 17 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/07ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

165 17 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/07ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

82	**That the federal government establish an entity for immigrants and refugees, similar to the Correctional Investigator, the Canadian Forces Ombudsman, or the RCMP External Review Committee;** **That this entity be authorized to investigate individual complaints as well as systemic areas of concern related to federal provision of programs and services that have an impact on the mental wellbeing of immigrants and refugees;** **That this entity provide an annual report to Parliament.**

The Committee supports greater involvement of immigrant and refugee communities as partners in research, program development and services delivery. There is a need for more Canadian research into the identification and evaluation of culturally appropriate systems of care for immigrant populations, particularly in relation to such vulnerable populations such as children, women and seniors.

There is a need for more Canadian research into the identification and evaluation of culturally appropriate systems of care for immigrant populations, particularly in relation to such vulnerable populations such as children, women and seniors.

Language is a key tool to facilitate successful integration and positive mental health among immigrants and refugees. All immigrants and refugees should have equal access to official language education. The federal government has an obligation to provide and pay for linguistically and culturally appropriate services; it must not offload them onto the provinces.

The Committee recommends:

83	**That Citizenship and Immigration Canada provide an annual inventory to Parliament on its programs and services relevant to mental health, including clients served, expenditures allocated and spent, and outcomes achieved, starting in 2008.** **That Citizenship and Immigration Canada increase funding for and access to language training by diverse groups through increased training allowances, appropriate scheduling of instructional hours, and the location of classes in places that facilitate access.**

13.7 FEDERAL PUBLIC SERVICE EMPLOYEES

> *As the country's largest employer, I want to assess what the federal government is doing to address mental health issues in the workplace. Simply stated, we need to be a leader and example for employers across the country. — The Honourable Ujjal Dosanjh, former Minister of Health.*[166]

13.7.1 Federal Responsibility

Through the authority of the *Financial Administration Act*, Treasury Board is the employer of the federal public service and responsible for labour relations, pensions and benefits, as well as employee and military compensation.[167] Other legislation also impacts on the working conditions of federal employees. For example, the *Employment Equity Act* requires federal employers to provide reasonable accommodation for persons with disabilities,[168] while the *Government Employees Compensation Act* authorizes compensation for loss of earnings, medical care and other related benefits to federal employees with employment-related injury or disability.[169]

According to the 2005 departmental performance report for the Treasury Board of Canada Secretariat:

> The federal public sector is the largest organization in Canada. With over $200 billion in expenditures, it is seven times larger than any other enterprise in the country. With 450,000 employees, 200 organizations, 400 million transactions a year and 1,750 points of service, it is arguably the most complex institution in Canada.[170]

13.7.2 Federal Programs and Services

The majority of federal public service employees rely on the governments of the provinces or territories in which they work for essential mental health services.

The majority of federal public service employees rely on the governments of the provinces or territories in which they work for essential mental health services. In its role of employer, the Treasury Board sets policies that govern the public service health care and the disability insurance plans for departmental and agency employees under its authority. These plans cover the cost of services and other benefits for mental health not available through other insurance plans.

The Public Service Health Care Plan (PSHCP) applies to Public Service employees, members of the Canadian Forces (CF), members of the Royal Canadian Mounted Police (RCMP),

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166 Public Health Agency of Canada, *News Release*, "Michael Wilson to serve as Special Ministerial Advisor on Mental Health," 4 February 2005.

167 *Financial Administration Act*, R.S. 1985, c. F-1, http://laws.justice.gc.ca/en/f-11/text.html.

168 *Employment Equity Act*, 1995, c.44, http://laws.justice.gc.ca/en/e-5.401/50293.html

169 *Government Employees Compensation Act*, Chapter G-5, http://laws.justice.gc.ca/en/g-5/63537.html.

170 Treasury Board, *Performance Report for the period ending March 31, 2005*, p. 13, http://www.tbs-sct.gc.ca/rma/dpr1/04-05/TBS-SCT/TBS-SCTd45_e.pdf.

pensioners, and their respective dependants.[171] A PSHCP Directive notes, however, that only eligible dependents of members of the CF and RCMP are covered; the members themselves are covered under their own specific plans.[172] The Plan reimburses participants for all or part of costs incurred for eligible services, only after they have taken advantage of benefits provided by the relevant provincial/territorial plans. The extended health provision includes coverage for services provided by a psychologist and prescribed by a physician up to $1,000 in a calendar year.

According to Phil Charko, Assistant Secretary, Pension and Benefits Division, Treasury Board Secretariat, in one year, the federal government paid out an estimated $64 million for prescribed drugs and $10 million on psychological services under the Public Service Health Care Plan.[173]

In one year, the federal government paid out an estimated $64 million for prescribed drugs and $10 million on psychological services under the Public Service Health Care Plan.

The Disability Insurance Plan is designed to give Public Service employees a measure of income protection. It provides for a monthly income benefit for employees who are unable to work for a lengthy period of time because of a totally disabling illness or injury. Income replacement during long-term disability can be up to 70% of an individual's annual salary. Benefits are payable for up to 24 months if the individual is totally disabled (i.e. in a continuous state of incapacity due to illness or injury, prevented from performing regular occupational duties). If, at the end of this 24-month period, the disability continues to prevent the performance of a commensurate occupation requiring similar qualifications, the benefit can be continued up to age 65 years.[174]

In 2003, 44 percent of new long-term disability cases were for anxiety and depression. He noted that this was "a fairly high number" but stressed that there is also a fairly high rate of recovery and return to work.

Mr. Charko pointed out that, in 2003, 44 percent of new long-term disability cases were for anxiety and depression. He noted that this was "a fairly high number" but stressed that there is also a fairly high rate of recovery and return to work. He suggested that approximately 70% of people who go on long-term disability return to work in the public service. According to him, the return to work involved:

> *... a flexible approach whereby individuals can come back temporarily in a less demanding job or can come back on reduced hours. If they are coming back*

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171 Treasury Board of Canada Secretariat, *Public Service Health Care Plan — Benefits Coverage and Plan Provisions*, July 2001, http://www.tbs-sct.gc.ca/pubs_pol/hrpubs/TB_862/pshcpb-rssfpp_e.asp.

172 Treasury Board of Canada, *Public Service Health Care Plan Directive*, April 2005, http://www.tbs-sct.gc.ca/pubs_pol/hrpubs/TB_862/pshcp_e.asp.

173 23 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

174 Treasury Board Secretariat, *Chapter 3-4, Long-term Disability*, http://www.tbs-sct.gc.ca/Pubs_pol/hrpubs/TB_865/CHAP3_4-PR_e.asp?printable=True.

> *on reduced hours, the [disability insurance] benefit is continued to the point where they are back to their main income.*[175]

For Mr. Charko, the successful management of mental health issues in the federal public services entails three factors:

> *If you have managers that are focused on [human resource] issues and well trained, that is one success factor. If you have a suite of work place policies that deal with leave and duty to accommodate employees with mental health problems, that is another success factor. The third deals with your insurance programs when in fact the employee finds himself in difficulty.*[176]

Mr. Charko indicated that a comprehensive set of workplace policies to assist federal employees and address issues such as mental health and addiction problems and work place well-being should:

> *... include things like flexible working arrangements, telework, job sharing, mobility policies, child care. We have generous leave policies, anti-harassment, fitness, duty-to-accommodate policies, employment equity, pride and recognition, and policies with respect to the code on values and ethics.*[177]

In relation specifically to the employee assistance program, Mr. Charko noted that it is mandatory in all government departments:

> *It provides for short-term confidential counselling. It is paid for by the department and allows for counselling of employees with all kinds of problems, not just mental health, without prejudice to job security or career.*[178]

13.7.3 Assessments of Client Group Needs

Federal government employees are located in every province and territory and work in communities of every size. They do many things: inspect food, report weather conditions, patrol fisheries, guard borders, staff correctional institutions, conduct scientific research, issue passports, assist in travel abroad, monitor infectious diseases, and have multiple other responsibilities.

While the federal government's policy framework to support its employees and to create workplaces conducive to their wellbeing seems appropriate, reports of actual experience with the individual programs and policies suggest that there are still many unresolved issues.

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175 23 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

176 23 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

177 23 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

178 23 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

Over the last decade, a number of factors that contribute to making federal workplaces more stressful present significant challenges to both the physical and mental health of federal employees. These include the cumulative affect of downsizing, restructuring, and devolution of authority, as well as constrained resources and intense media scrutiny in the wake of a variety of controversies and scandals.

This increase in stress at the workplace is illustrated by the results of internal surveys conducted by Treasury Board Secretariat.[179] Significant numbers of survey respondents reported being pressured in their jobs and confused by constantly changing priorities. Respondents indicated that they are experiencing instability in their departments and are being left out of decision-making processes in areas that directly affect their work. Twenty-one percent reported having been the victims of harassment, and 17% reported having been discriminated against in the workplace.

The National Joint Council, a body that includes public service bargaining agents and Treasury Board representatives, strives to find collaborative solutions to workplace problems. It reported that the Disability Insurance Plan delivered $223 million in 2004 in support to affected employees. The Council pointed out that:

> Psychological conditions including stress and anxiety remained the major cause of disability for new claims in 2004 as it has in the last thirteen (13) years. Increasingly cases presented deal less with objective verifiable medical data verified by traditional diagnostic protocols and more with the challenges that are posed by the difficulty of diagnosing these illnesses.[180]

Mr. Charko asserted that a work place in which individual differences are respected "can do a lot to eliminate the stigma associated with mental illness which is a problem in the public service." In this regard, the Treasury Board Secretariat has developed a Policy on the Duty to Accommodate Persons with Disabilities in the Federal Public Service[181] in response to a requirement of the *Employment Equity Act* that employers provide reasonable accommodation for persons with disabilities. The guideline definition of persons with disabilities that accompany this policy includes individuals who suffer from a "long-term or recurring physical, mental, sensory, psychiatric, or learning impairment."[182]

While the federal government's policy framework to support its employees and to create workplaces conducive to their wellbeing seems appropriate, reports of actual experience with the individual programs and policies suggest that there are still many unresolved issues. For example, Alan Fournier, a federal employee diagnosed with mental disabilities who

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179 Public Service Human Resources Management Agency of Canada, *2002 Public Service Employee Survey, Organizational Report*, http://www.hrma-agrh.gc.ca/survey-sondage/2002/results-resultats/00/result-e.htm.

180 National Joint Council, *2004 Annual Report of the Disability Insurance Plan Board of Management*, http://www.njc-cnm.gc.ca/auxFile.php?AuxFileID=260.

181 Treasury Board Secretariat, *Policy on the Duty to Accommodate Persons with Disabilities in the Federal Public Service,* 2002, http://www.tbs-sct.gc.ca/pubs_pol/hrpubs/TB_852/ppaed_e.asp.

182 Treasury Board Secretariat, *Creating a Welcoming Workplace for Employees with Disabilities*, http://www.tbs-sct.gc.ca/pubs_pol/hrpubs/TB_852/cwwed1_e.asp#Definition.

submitted a brief to the Committee, indicated that "there have been those in the Public Service who have been very helpful and supportive. However, they are in the minority." He told the Committee that he was:

> *... not pointing at any one individual or organization with [in] the public service. Rather, the problem seems to [be] more systemic in nature from a culture that talks the talk but will often not walk the walk on disabilities such as mine.*[183]

Mr. Fournier also referred to the limited coverage for professional services provided by the Public Service Health Care Plan.

> *An overwhelming number of those of us seeking the services of therapists rely on professionals not covered by provincial heath plans. Therefore we are limited to the $1000.00 annual coverage of the public service health care plan. Most addiction therapists and psychologists charge at least $100.00 a session. In my case I require a number of professionals including an Addiction Therapist and a Psychologist who is a Learning Disability Specialist. At their rates, I am limited to eight visits annually. Effective therapy, especially at the early stages of addiction is required on a weekly basis. I should be seeing my addiction therapist bi-weekly. I also require a substantial number of expensive prescriptions. Even at eighty percent coverage I often find myself in financial difficulties meeting the difference. The requirement to pay medical expenses up front means a substantial portion of my income is always in transit waiting for claims to be processed.*[184]

Dorothy Cotton, Co-chair/Psychologist, Canadian National Committee for Police/Mental Health Liaison, pointed to the fact that, in practice, the way the federal government, as an employer, treats its psychologists actually contributes to the overall stigma of mental illness:

The way the federal government, as an employer, treats its psychologists actually contributes to the overall stigma of mental illness.

> *The Federal Government is a bad employer in this way. You know, wages are easily 30% below market value for psychologists in the Federal Government scales, it is humiliating, and which contributes to the whole stigma issue.*[185]

Diana Capponi, consumer/advocate, was pleased that the federal Minister of Health had appointed the Hon. Michael Wilson and Bill Wilkerson to review issues relating to mental health and the workplace within the federal government. However, she cautioned that:

> *Being Canada's largest employer, I would suggest there are changes to be made. I would hope that these changes would include the targeted recruitment of people*

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183 Brief submitted 30 March 2005.

184 Brief submitted 30 March 2005.

185 16 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/06eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

with mental health or addiction issues, and that the Federal Government will go well beyond the efforts of our banking sector, in that all positions, all levels or classifications of employees be filled by people with mental health and addiction issues. This would demonstrate to the Canadian public and your employees that you are "Walking the talk."[186]

13.7.4 Committee Commentary

The Committee notes the initiatives taken by the former federal Minister of Health, the Hon. Ujjal Dosanjh, to focus attention on mental health issues in the public service. One example was the February 2005 appointment of the Hon. Michael Wilson, now Ambassador to the United States, as special ministerial advisor on mental health in the federal government workplace.[187]

In Chapter 8 on general workplace issues, the Committee drew heavily on the work of the Global Business and Economic Roundtable on Addiction and Mental Illness (the Roundtable), that was founded in 1998 to serve as an "instrument of information analysis and ideas concerning the linkage between business, the economy, mental health and work."[188] Among employers, the Roundtable has raised the level of awareness of mental health issues and has facilitated the sharing of best practices. Indeed, effective solutions and approaches to promoting better workplace wellbeing have already been developed by the private sector.

The federal government, as an employer, could benefit from the establishment of wider community relationships in developing better practices for its own workplaces, in particular, the elimination of the stigma associated with mental illness.

The federal government, as an employer, could benefit from the establishment of wider community relationships in developing better practices for its own workplaces, in particular, the elimination of the stigma associated with mental illness.

The Committee therefore recommends:

84	**That the federal government draw upon the model established by the Global Business and Economic Roundtable on Addiction and Mental Illness in coordinating interdepartmental mental health policies, programs and activities for employees.**

[186] 15 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/05eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

[187] Public Health Agency of Canada, *News Release*, "Michael Wilson to serve as Special Ministerial Advisor on Mental Health," 4 February 2005.

[188] Global Business and Economic Roundtable on Addiction and Mental Health, website, http://www.mentalhealthroundtable.ca/about_us.html.

That the federal government, as an employer, form a partnership with other sectors and jurisdictions, including the Global Business and Economic Roundtable on Addiction and Mental Health, to stimulate and facilitate the exchange of best practices in the support of workplace wellbeing and better employee mental health.

That, as it develops strategies to support mental health in its workforce, the federal government place a specific emphasis on measures that will reduce and eventually eliminate the stigma attached to mental illness.

The Committee believes it essential to evaluate programs regularly to see whether they are meeting their objectives and satisfying real needs. To determine the efficacy of the programs and policies currently in place that are designed to assist government employees facing mental health problems, the federal government must do more than simply list the programs and policies.

Accordingly, the Committee recommends:

85	**That the Public Service Human Resources Management Agency conduct annual evaluations of the federal government's provision of policies, programs, and activities designed to support mental health in the public service;** **That these evaluations be based on clear performance indicators that include the use of surveys to assess employee satisfaction;** **That the evaluations be used as a basis for adjustments to policies, programs, and activities in order to better suit them to the needs of employees;** **That results of these evaluations, and the adjustments that were made based upon them, be reported to Parliament on an annual basis starting in 2008.**

13.8 TOWARD A FEDERAL GOVERNMENT STRATEGY FOR FEDERAL CLIENTS

Federal clients, like all Canadians, need a range of programs and services to sustain or attain positive mental health. As we have seen throughout this chapter, each federal client group confronts particular challenges and each requires solutions specifically targeted to their needs. Thus, for example, attention to fundamental determinants of health such as housing and community supports are a crucial factor among veterans and First Nations and Inuit populations. For federal public service employees, on the other hand, workplace conditions and accommodations for people living with a mental disorder are of prime importance.

It is also important to reiterate that the federal government is responsible for these different client groups for varying periods of time. Some, like First Nations and Inuit, are clients for life. Veterans generally access mental health services at a later stage in their lives. Refugees, as they gain access to provincial services, may be able to stop relying on the federal government within a few months of arrival in Canada, while federal offenders remain in the care of the federal government until their release. Others, like the RCMP, Canadian Forces members and public servants, are the responsibility of the federal government for as long as they are employed within the federal jurisdiction.

The Committee cannot understand why the federal government has never developed a clear and consistent approach to address the concerns of the client groups for which it is responsible.

The Committee believes it necessary to develop such a comprehensive strategy aimed at improving the health status of all federal client groups while acknowledging also the distinct needs of each group.

The Committee recognizes that this wide range of situations poses a challenge to the federal government in ensuring that the necessary programs and services for mental health, mental illness and addiction are available to all clients. Nevertheless, the Committee cannot understand why the federal government has never developed a clear and consistent approach to address the concerns of the client groups for which it is responsible. The Committee believes it necessary to develop such a comprehensive strategy aimed at improving the health status of all federal client groups while acknowledging also the distinct needs of each group.

The Committee therefore recommends:

86	**That the federal government develop a strategy for mental health that is inclusive of all federal client groups and that takes into account each group's particular needs.** **That the strategy set goals, including a timetable for implementation and for subsequent evaluation.** **That the strategy have as its objective making the federal government a model employer as well as model provider with respect to its various clients.**

13.8.1 Incorporating a Determinants of Health Approach

Historically, the federal government has been a leader in the development of the concepts of population health, starting with the landmark Lalonde report. The Committee believes that the government has both the opportunity and obligation to apply these concepts to its own clientele.

The Committee believes that the government has both the opportunity and obligation to apply population health concepts to its own clientele.

In 2004, the federal government reported that it was the fifth-largest provider of health services to Canadians, serving approximately 950,000 people at a cost of $3.4 billion

annually.[189] The Committee believes that the federal government's commitment to mental health must include a focus on the determinants of health that extends beyond health services as such, given the many factors relevant to the various client groups. These encompass a range of determinants including: adequate housing, access to income, the presence of social support networks, as well as educational opportunities and the availability of employment.

Given its substantial responsibilities for the provision of mental health service, the federal government must lead by example.

Given its substantial responsibilities for the provision of mental health service, the federal government must lead by example, including by focusing on the promotion of mental health and the prevention of mental illness and addictions. Through interdepartmental collaboration and sustained work with its client groups, the federal government could set a standard for the whole country in the development and application of population health models.

The Committee therefore recommends:

87	**That the mental health strategy to be developed by the federal government incorporate a population health approach to the determinants of mental health, and that it specifically address the economic, educational, occupational and social factors that have an impact on the mental health of all federal clients;** **That the federal government report to Parliament in 2008 on what precisely it is doing to implement a population health approach for federal clients.**

13.8.2 Initiating Anti-Stigma Activities

In Chapter 16, the Committee recommends that the Canadian Mental Health Commission undertake a sustained, ten-year campaign to combat the stigma associated with mental illness. The presence of a federal representative on the Board of the Mental Health Commission will provide a federal input into the Commission's pan-Canadian anti-stigma campaign. The Committee believes, however, that the federal government also has a responsibility to lead directly in reducing the stigma associated with mental health among its specific client groups.

The Committee recommends:

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189 Health Canada, *Healthy Canadian: A Federal Report on Comparable Health Indicators*, 2004, http://www.hc-sc.gc.ca/hcs-sss/pubs/care-soins/2002-fed-comp-indicat/2002-health-sante4_e.html.

	That the federal government immediately develop and implement an anti-stigma campaign for all federal client groups.

13.8.3 Providing an Avenue of Redress

The Committee has recommended that the responsible federal departments establish similar forums for other federal client groups like veterans, First Nations and Inuit, immigrants and refugees that currently have no recourse to such a person or entity.

As stated previously in this chapter, over several decades various federal departments have established some form of external independent, impartial oversight body for a broad range of matters affecting federal clients. Many of these entities are mandated to include reviews of mental health concerns. For example, the Correctional Investigator and the RCMP External Review Committee are mandated through legislation to investigate and assess mental health issues, as well as other issues of concern relevant to their respective groups; they report to the relevant federal ministers with recommendations for action. Others like the Canadian Forces Ombudsman and the special advisor on mental health in the federal government workplace have no legislated mandate.

The Committee has recommended that the responsible federal departments establish similar forums for other federal client groups like veterans, First Nations and Inuit, immigrants and refugees that currently have no recourse to such a person or entity.

As part of the overall federal strategy, the Committee believes it is important to link oversight positions within individual departments to each other to provide a coordinated federal ombudsman role for specific issues relating to mental health. It envisions an entity that can investigate and resolve individual complaints, review and make recommendations, identify systemic areas of concern, and follow-up for clients from all federal client groups.

The Committee recommends:

89	**That the federal government establish a central coordinating mechanism for the development and delivery of mental health policies, programs, and activities across its departments and agencies;** **That this federal body work with the Correctional Investigator, the Canadian Forces Ombudsman, and the RCMP External Review Committee and other similar entities to be established by departments to ensure that the needs of individual client groups are being addressed;**

That this federal body coordinate and monitor the work of these individual entities in investigating and getting responses to concerns about mental health services for each federal client group;

That this federal body provide an annual report to Parliament.

13.8.4 Assessing Federal Insurance for Mental Health

The federal government is completely responsible for the provision of health programs and services to three client groups — Canadian Forces, RCMP and federal offenders. Others — First Nations and Inuit, veterans, immigrants and refugees and federal employees — are under federal responsibility to significant but varying degrees. The federal government believes that provincial governments should shoulder the broad responsibility for the health of these latter groups of clients just as they do for the general Canadian population.

The conditions established under the *Canada Health Act* (*CHA*) that must be met by provincial health-care insurance plans to receive federal cash transfers expressly exclude some federal client groups. Under "insured health services," the *CHA* excludes "any health services that a person is entitled to and eligible for under any other Act of Parliament." It also excludes any "hospital or institution primarily for the mentally disordered." More specifically, it defines "insured persons" for whom health services would be provided under provincial health care plans to mean a resident of the province, other than:

> "(*a*) a member of the Canadian Forces,
> (*b*) a member of the Royal Canadian Mounted Police who is appointed to a rank therein,
> (*c*) a person serving a term of imprisonment in a penitentiary as defined in the *Penitentiary Act*."[190]

Each client group has mental health needs that are not covered under provincial insurance plans. To meet these uninsured needs, the federal government has developed a separate approach for each client group.

Thus, the federal government is completely responsible for the provision of health programs and services to three client groups — Canadian Forces, RCMP and federal offenders. Others — First Nations and Inuit, veterans, immigrants and refugees and federal employees — are under federal responsibility to significant but varying degrees.

The federal government believes that provincial governments should shoulder the broad responsibility for the health of these latter groups of clients just as they do for the general Canadian population. As Ian Potter explained with reference to First Nations and Inuit clients:

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[190] *Canada Health Act*, Chapter C-6, Section 2 — Interpretation, http://laws.justice.gc.ca/en/C-6/17077.html#rid-17084.

> *... those services that are covered by the Canada Health Act, what we call insured services, are provided by the province. If the federal government is arranging for physician services or hospital services, we charge the province back for those services.*[191]

However, each client group has mental health needs that are not covered under provincial insurance plans. To meet these uninsured needs, the federal government has developed a separate approach for each client group. The Canadian Forces, RCMP and Corrections Canada cover non-insured health care and mental health treatment as a matter of operational necessity; First Nations and Inuit have access to the Non-Insured Health Benefits Program; veterans have the Health Benefits Program; refugees have the Interim Federal Health Program; and public servants have the Public Service Health Care Plan. In addition, there are a variety of disability insurance plans.

George Lucki, Chair, Alberta Alliance on Mental Illness and Mental Health, noted that federal efforts to cover the additional needs of its clients were characterized by a lack of coordination with the provinces:

> *The federal government is a leading purchaser of uninsured benefits that provide those who work for the federal government or those whose health care is a federal responsibility with mental health care that is not available to the people of Canada at large.*
>
> *These services themselves are often not particularly well coordinated with other health services that are delivered by provincial authorities. We believe that these programs should be comprehensibly reviewed to ensure that they reflect best practices, address the mental health needs of those they serve.*[192]

The Committee was surprised to learn not only about the wide range of insurance plans that exist to cover federal clients, but also about the lack of coherent reporting on and assessment of these plans. Health Canada's Non-Insured Health Benefits Program for First Nations and Inuit was the only plan that provided a comprehensive annual report to Parliament. The Committee heard occasional references to other plans but received no formal descriptions or reports.

The Committee was surprised to learn not only about the wide range of insurance plans that exist to cover federal clients, but also about the lack of coherent reporting on and assessment of these plans.

The Committee therefore recommends:

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[191] 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/13eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

[192] 9 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/21evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

That the federal government immediately undertake an assessment of all of its insurance plans for all federal clients to determine their applicability and effectiveness;

That this assessment include a comparative evaluation of benefits, of coverage for specific mental health, mental illness and addiction needs, of administrative costs, and of results achieved under the various insurance plans;

That this review of insurance plans be reported to Parliament in 2008.

13.8.5 Coordinating and Reporting to Parliament

In 2005, the Minister of Health initiated an interdepartmental task force to identify better ways to integrate services and approaches between federal departments with a stake in mental health issues. This task force includes representation from 20 departments and agencies and is jointly led by Health Canada and the Public Health Agency of Canada. Its mandate is to study federal activities and improve coherence in the areas of mental health promotion and prevention, the provision of services, and policy development. The Committee believes that this is an important first step in the right direction, but sees the need for the federal government to go much further in its efforts to coordinate its various programs and services.

Despite the presence of policies, programs, and activities in numerous departments and agencies of the federal government that address the mental health needs of various client groups, the Committee found no central source with overall knowledge of federal activities in this area. There is no forum in which the exchange of solutions and best practices can occur, and no single source of information on the availability of programs, their cost, or their performance.

Despite the presence of policies, programs, and activities in numerous departments and agencies of the federal government that address the mental health needs of various client groups, the Committee found no central source with overall knowledge of federal activities in this area. There is no forum in which the exchange of solutions and best practices can occur, and no single source of information on the availability of programs, their cost, or their performance. Importantly, no one has a complete picture of either the state of mental health of federal clients or of the full range of services available to support them. This lack of coordination can only lead to overlap and wasteful duplication of effort.

The federal government does not provide comprehensive and coordinated annual reports to Parliament on any aspect of its provision of health and health care services.

The Committee also believes it essential for the federal government to provide regular reports to Parliament on its mental health programs and services.

The Committee also believes it essential for the federal government to provide regular reports to Parliament on its mental health programs and services. At present,

Parliamentarians are expected to make decisions about mental health, mental illness and addiction for federal clients without having access to full information. For example, when the Auditor General of Canada reported in 2004 on federal drug benefit plans, she noted that, while federal organizations have highly useful and current data about drug use, that information is not systematically assessed or disseminated to facilitate meeting client health needs.[193]

Under the *Canada Health Act*, each provincial and territorial government is required to submit a report annually on physician, hospital and other relevant health services.

While departments provide some limited details in their plans and priorities or performance reports, no full reporting on federal health programs is made to Parliament. The Committee notes that, under the *Canada Health Act*, each provincial and territorial government is required to submit a report annually on physician, hospital and other relevant health services. In the meantime, the federal government does not provide comprehensive and coordinated annual reports to Parliament on any aspect of its provision of health and health care services.

The Committee has already called for reports from individual departments with significant responsibility for the mental health of particular groups of Canadians. It wants a coordinated approach to this reporting to provide Parliament with the comprehensive information it needs to make legislative and budgetary decisions affecting these specific clients.

The Committee therefore recommends:

91	**That all federal departments with direct program and service responsibility for specific client groups — including First Nations and Inuit, federal offenders, immigrants and refugees, veterans, Canadian Forces, RCMP, and federal public service employees — develop an annual report that includes a description of federal responsibility, federal programs and services, and the extent to which these meet the mental health needs of clients;** **That this annual report include an annual inventory of their current respective programs and services as well as a three-year comparison;** **That the inventory include a clear description for each program or service by fiscal year of the criteria for eligibility, of the number of clients served by the program, of the amount of funding allocated and the amount spent, as well as an evaluation of outcomes related to the determinants of mental health;** **That the inventory be tabled in Parliament annually starting in 2008.**

[193] Auditor General of Canada, *Management of Federal Drug Benefit Programs*, Chapter 4, November 2004, http://www.oag-bvg.gc.ca/domino/reports.nsf/html/20041104ce.html/$file/20041104ce.pdf.

14.1 INTRODUCTION

> *... for Aboriginal people the health continuum is about wellness and not illness. Aboriginal mental health is relational because strength and security are derived from family and community. Apart from sharing healing traditions, Aboriginal communities are bound by a concept of wellness wherein the mind, body, spirit and soul are interconnected. —Debbie Dedam-Montour*[194]

For too many Aboriginal peoples, the wellness continuum has been seriously disrupted. Individuals and communities wage a daily battle with adverse conditions in their physical, social and emotional environments. For large numbers, the outcomes are chronic unemployment, violence, addictions and suicide. The Committee can reach only one conclusion — Canada's record of treatment of its Aboriginal citizens is a national disgrace.

The Committee can reach only one conclusion — Canada's record of treatment of its Aboriginal citizens is a national disgrace.

Despite multiple reports and substantial allocations of human and financial resources, the overall mental health of Aboriginal peoples continues to be at serious risk. Their mental health is located at the extreme negative end of the continuum.

It is highly misleading, moreover, to speak of Aboriginal peoples as a single homogeneous unit. The *Constitution Act, 1982* recognized three groups of Aboriginal peoples — defined as the "Indian, Inuit and Métis peoples of Canada."[195] Witnesses, acknowledging the diversity that exists between and within each of these groups, emphasized:

> *To have a fundamental impact on the mental health of Aboriginal peoples, a number of changes or actions must take place. Policies, programs and procedures developed by the government need to be respectful and inclusive of all First Nations, Métis and Inuit concepts of health and healing. —Bernice Downey*[196]

The Committee struggled with the knowledge that, despite multiple reports and substantial allocations of human and financial resources, the overall mental health of Aboriginal peoples continues to be at serious risk. Taking the rates of suicide and of addiction as measures, their mental health is located at the extreme negative end of the continuum. Witnesses expressed frustration over the frequency of governmental consultations and the absence of actions that lead to improved outcomes. In the words of one presenter:

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194 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

195 Throughout the chapter, references to Aboriginal peoples are intended to include individuals who identify themselves as First Nations, status Indians, non-status Indians, Métis, or Inuit.

196 21 April 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/13evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

The reality is that our comments and our suggestions are documented, but it has yet to be proven that they have been implemented. —Lorraine Boucher[197]

The Committee acknowledges that it cannot in a single chapter review the long and negative legacy of Canada's Aboriginal peoples. Our intent in this chapter is to give another voice to the individuals who took the time to share their ideas with us. The Committee heard that the same factors that promote wellness for Aboriginal peoples — family and community support, economic opportunities, social and physical security, etc. — are, in their absence, the ones that create the need for healing. We heard also that if Aboriginal peoples could take ownership and control of their personal and community health, much of their present ill-health would be prevented.

14.1.1 A National Aboriginal Advisory Committee

The Committee wants to ensure that ongoing national mechanisms are put in place to provide avenues for obtaining the advice of Aboriginal peoples and translating it into action. In its recommendation to create a Canadian Mental Health Commission (see Chapter 16), the Committee incorporated three specific measures designed to guarantee that this happens. First, one of the governmental nominees will be a representative of the territorial governments, and will therefore be in a position to speak to the specific concerns of Aboriginal people living in the north. Second, the Commission report specifies that the non-governmental members of the governing Board of the Commission must include people who have experience of, and understand the issues confronting, people of Aboriginal origin. Third, of the two advisory committees that must be put in place by the Commission, one must be an Aboriginal Advisory Committee.

The Committee wants to ensure that ongoing national mechanisms are put in place to provide avenues for obtaining the advice of Aboriginal peoples and translating it into action.

Within the structure of the Mental Health Commission, the Aboriginal Advisory Committee will have a status equivalent with and parallel to the status of the advisory committee representing the provincial and territorial governments.

The Committee recognizes that a report such as this one that is focused on mental health, mental illness and addiction cannot address all the broad constitutional, policy and governance issues that have a real impact on the health and well-being of Aboriginal peoples. However, the Committee strongly believes that its recommendations for improving the mental health of Aboriginal peoples may help open the door to broader initiatives.

In this regard, it should be noted that, besides the Aboriginal Advisory Committee, the Mental Health Commission is required to create only one other advisory committee which will be composed of representatives of all the provincial and territorial governments. Thus, within the structure of the Mental Health Commission, the Aboriginal Advisory Committee will have a status equivalent with and parallel to the status of the advisory committee representing the provincial and territorial governments.

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[197] 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

For the Committee, this Aboriginal Advisory Committee is a vital component of a larger (and longer-term) endeavour aimed at significantly improving the mental health and well-being of all Aboriginal peoples. The Committee believes that the Aboriginal Advisory Committee will provide a crucial focal point for furthering the development of a specific strategy for mental health that reflects the distinct approaches needed by all groups of Aboriginal peoples. As the following sections emphasize, this strategy must be based on the recurring calls by Aboriginal peoples for community authority and control, cultural accommodation, and equity of access with respect to mental health programs and services.

The Committee also believes that the recommendations it makes in this report for ensuring that Aboriginal peoples themselves are fully involved in the design and delivery of improved mental health services and supports are entirely consistent with the community-based orientation for mental health that the Committee is advocating for the general population. It therefore hopes that the Aboriginal Advisory Committee will be able to promote a fruitful two-way dialogue within the Mental Health Commission that will allow non-Aboriginal Canadians to learn from the experience and traditions of Aboriginal Canadians in promoting mental health and well-being.

The Committee thus emphasizes the recommendation made in Chapter 16:

92	**That the Canadian Mental Health Commission (see Chapter 16) establish an Aboriginal Advisory Committee comprised of representatives of Aboriginal communities, whose membership shall be determined by the Commission in consultation with Aboriginal organizations, and shall provide representation from First Nations, Inuit and Métis and broadly reflect the geographic distribution of Aboriginal communities across the country.**

14.2 WELLNESS AS THE GOAL

Witnesses representative of all Aboriginal peoples emphasized that the focus must be changed from mental illness to mental wellness. They called for a holistic and comprehensive approach addressing all determinants of health.

Witnesses representative of all Aboriginal peoples emphasized that the focus must be changed from mental illness to mental wellness. They called for a holistic and comprehensive approach addressing all determinants of health.

Valerie Gideon, Director of Health and Social Secretariat, Assembly of First Nations, noted a call for a comprehensive and holistic First Nations wellness strategy:

> *Certainly, that strategy would have mental health and suicide prevention as a key point of focus. It would look at a holistic approach for mechanisms that would enable communities to have the flexibility to allocate resources toward priorities and make linkages with some of the health determinants that are*

fundamental, such as education, housing, and social and environmental issues.[198]

The Inuit also seek an approach reflective of their particular circumstances. According to Onalee Randell, Director of Health, Inuit Tapiriit Kanatami, Inuit need:

> *a…continuum of services that incorporates traditional knowledge and practices that are based in their home community or, at a minimum, their home region; …that provides supports for individuals and families; and services that breach the barriers and [address] both the medical and non-medical determinants of mental wellness, including economic and environmental matters, and housing and education.*[199]

Although few Métis organizations participated directly in Committee proceedings, Bernice Downey, Executive Director, National Aboriginal Health Organization, presented the perspective of the Métis health unit. She emphasized that the development of a comprehensive and inclusive plan for mental health, mental illness and addiction:

> *…hinges on the awareness of the governments to acknowledge and respect not only the jurisdictional rights of Metis, but also the concept of health and wellness from a Metis perspective.*[200]

14.2.1 Mental Health Rather Than Mental Illness

Talking only about mental illness constitutes, for most witnesses, a negative, stigmatizing approach that discourages people from raising particular mental health issues. Some like Arnold Devlin, Dilico Ojibway Child and Family Services, argued that:

Witnesses spoke of the need to adopt a holistic approach to address an individual's spiritual, emotional, mental and physical needs when placed against the external social, cultural, economic and political reality experienced by that individual.

> *It is important to differentiate between mental problems and mental illness. There is no reason to expect, and I see no evidence that mental illness is any greater within the native community than it is in the general population. The fact that we have more mental problems is true. That is what we are referring to and looking at. There is a highly significant difference between the two.*[201]

He emphasized that, for many Aboriginal peoples, the outward manifestations of their situation should be seen "as mental distress versus mental illness. The level of mental

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198 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

199 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

200 21 April 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/13evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

201 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

distress can be a specific episode that lasts a certain length of time but I would not classify it as a mental illness."[202]

The Committee heard that Aboriginal peoples are not more predisposed than anybody else to particular mental illnesses but that individuals can manifest profound inability to manage in Canadian society, a powerlessness too often expressed as depression, suicide and addiction. Elsie Bastien, Aboriginal Liaison Coordinator, Alberta Mental Health Board, argued that:

> *Mental health is a concern for Aboriginal communities not because Aboriginal people have higher rates of severe mental illness such as schizophrenia, but because so many show signs of low level yet debilitating disturbances. The indicators of this are the high rates of alcohol and drug abuse, suicide, accidents, violence, as well as educational failure, unemployment and incarceration.*[203]

To prevent or to address these negative outcomes, witnesses spoke of the need to adopt a holistic approach to address an individual's spiritual, emotional, mental and physical needs when placed against the external social, cultural, economic and political reality experienced by that individual. As expressed by Sheila Levy, President, Nunavut Kamatsiaqtut Help Line:

> *Poverty, crime, violence, addictions, all categories of abuse, overcrowded housing, alienation, abandonment and suicide are all connected to mental and physical well-being. That interconnectivity of mental health issues is often forgotten.*[204]

14. 3 WELLNESS THROUGH HEALING

Achieving the emotional wellness desired by and for the individuals, families, and communities of all Aboriginal peoples requires healing. While recognizing the continuing impact of past injustices, witnesses expressed a strong desire to move forward using healing practices appropriate to their traditional cultures.

Bernice Downey talked about the Métis perspective on healing that:

> *...includes the provision of services in their Aboriginal language and the inclusion of traditional knowledge and healing practices.*[205]

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202 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

203 9 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/21evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

204 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

205 21 April 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/13evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

Jennifer Dickson, Executive Director, Pauktutit Inuit Women's Association, called for:

> *...a healing centre in each of Canada's remote Arctic communities. Well-trained mental health resource people must be available. These centres might provide places where Inuit elders, adults, youth and organizations could truly listen to each other and involve each other in meaningful interventions and traditional healing.*[206]

Bill Mussell, Chair, Native Mental Health Association, insisted that, if First Nations people had the chance to understand their past through healing processes, they would adopt healthier ways of coping:

Witnesses expressed a strong desire to move forward using healing practices appropriate to their traditional cultures.

> *When you think about grieving, healing, and the effects of trauma, there is a process of helping people to get in touch with what happened so they can continue to grow and develop. They must get in touch with their experiences. This process can be successful when performed with people who care about them that can provide them with the safety that is necessary to begin to get in touch with the dynamics of their life.*[207]

14.3.1 The Need for Healing

In addition to socio-economic and situational factors, the Royal Commission on Aboriginal Peoples identified culture stress brought about by the loss of land and control over living conditions, suppression of belief systems and spirituality, weakening of social and political institutions, and racial discrimination as destructive forces that continue to damage the confidence and overall health of Aboriginal peoples.[208]

Of the almost 1 million Aboriginal people currently in Canada, over one-third have been affected either directly by residential school experiences or indirectly as family or community members linked to survivors.

To understand fully the need for healing, Tarry Hewitt, Project Coordinator, Aboriginal Survivors for Healing, reminded Committee members that:

> *...the historical context is critical. In revisiting the impact of colonization and, in particular, the legacy of the residential school system, it may appear that we are going over old ground already dealt with in the previous reports produced by*

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206 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

207 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

208 Royal Commission on Aboriginal Peoples. (2005) Choosing Life: Special Report on Suicide Among Aboriginal Peoples.

> *this committee. However, it is important to connect the dots to examine how we got here from there in order to understand how to move ahead.*[209]

According to Gail Valaskakis, Director of Research, Aboriginal Healing Foundation, the trauma for Aboriginal people exposed to residential schools will take several generations to remedy:

> *It has to do with the loss that people who attended residential schools suffered in regard to language, to culture, to family, to nation, and with the impact that had on Aboriginal communities with respect to a cycle of abuse over a long period of time; in regard to the lack of parenting skills that related to their experience in residential schools and historical trauma — something we have learned a great deal about lately — with regard to the grief and loss that Aboriginal people have felt over many years of displacement, loss of culture, loss of language and death in their own communities.*[210]

She estimated that "it takes a community an average of 10 years to reach out, to dismantle denial, to create safety and to engage participants in the therapeutic healing process."[211] Of the almost 1 million Aboriginal people currently in Canada, over one-third have been affected either directly by residential school experiences or indirectly as family or community members linked to survivors.

14.4 STRATEGY FOR WELLNESS AND HEALING

The pressing need is for a wellness and healing strategy with a clear action plan that can and will be implemented.

So what is the way to build and to restore wellness for all Aboriginal peoples? Out of the many individual submissions and interventions, one message emerged clearly. For First Nations, Inuit and Métis, the pressing need is for a wellness and healing strategy with a clear action plan that can and will be implemented. People want action on overall mental health that will produce positive results for their communities.

The strategy must be inclusive of all groups — Indian (status and non-status), Métis and Inuit — from all regions of Canada.

In 2001, the North American Indian population was the largest, at 62%, of the total self-identified Aboriginal population of Canada. Of those North American Indian individuals, about 505,000 were registered Indians with legal status and 104,000 were not registered and lacked legal status. Métis represented about 30% of self-identified Aboriginal peoples, about

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209 16 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/22evc-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

210 21 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/23evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

211 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

292,000 individuals in total. Inuit represented about 5% of the self-identified Aboriginal peoples, enumerated at about 45,000.[212]

The multiplicity of individuals who identify themselves as Aboriginal people makes it difficult to generalize about overall mental health status and needs. As well, witnesses emphasized the value of approaches designed to meet the specific needs of each particular group:

> *Just as we now know that the mainstream approaches do not work, are not totally effective, we know that a cookie-cutter application to the three constitutionally recognized groups is not the answer either. It must be specific to the Nations. —Bernice Downey*[213]

And what are some key components of such a compilation of strategies? Witnesses stressed that any approach must be focused on the broad determinants of health and involve participation and cooperation across the economic, social, cultural and health sectors.

Any approach must be focused on the broad determinants of health and involve participation and cooperation across the economic, social, cultural and health sectors.

> *A comprehensive strategy must include changes to the education system and ways to create economic development opportunities; is not just a look at mental health and family violence and suicide. They are all interrelated — there is interconnectedness. —Debbie Dedam-Montour*[214]

> *Economic opportunities, adequate and effective housing, improved education, gender equity, actions to protect the environment and attention to justice issues are some of the issues that cry for a strong, holistic approach. —Jennifer Dickson*[215]

Virtually all witnesses saw the current jurisdictional quagmire as the primary barrier to progress toward wellness and positive mental health. While all groups of Aboriginal peoples (whether First Nations, Métis or Inuit) face disadvantages, each has been forced, through legislative and administrative channelling, into a different relationship with the federal government and hence into different program and service delivery situations with the

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212 The information is based on data provided by Statistics Canada for the health sectoral table of the Canada-Aboriginal Roundtable, November 2004. It includes four documents: A profile of Canada's North American Indian population with Legal Indian Status; A profile of Canada's North American Indian population without Legal Indian Status; A profile of Canada's Métis population; The Inuit population in Canada. http://www.aboriginalroundtable.ca/sect/hlth/index_e.html.

213 21 April 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/13evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

214 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

215 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

provincial and territorial governments. Frustration led Donna Lyon, Director, National Aboriginal Health Organization, to call on the federal government to acknowledge that:

> *...health programs to all three Aboriginal peoples is a federal, constitutional or treaty obligation as the case may be...*[216]

Witnesses were clear about the necessary building blocks of a successful strategy. They emphasized the need to focus on the determinants of health and on clarification of the jurisdictional and departmental confusion currently surrounding responsibility for the overall health status of Aboriginal peoples. They insisted that, if such a strategy is implemented, many of the negative mental health problems currently facing individuals and communities will be prevented.

Virtually all witnesses saw the current jurisdictional quagmire as the primary barrier to progress toward wellness and positive mental health.

The Committee strongly supports the development of a strategy oriented to promotion of wellness, to restoration of positive mental health and to prevention of worsening mental health outcomes for Aboriginal peoples.

The strategy must focus on recognized partnerships and meaningful collaboration.

The Committee strongly supports the development of a strategy oriented to promotion of wellness, to restoration of positive mental health and to prevention of worsening mental health outcomes for Aboriginal peoples. The strategy must be capable of measurably improving the aggregate health status of all Aboriginal peoples and take into account the distinct needs of First Nations, Inuit and Métis regardless of where they live. The strategy must focus on recognized partnerships and meaningful collaboration across social, economic, health and other sectors. The overall goal is to identify flexible, multi-dimensional solutions for the complex problems facing Aboriginal peoples through genuine community participation and shared power to implement change.

In 2003, the First Ministers directed their Health Ministers to consult with Aboriginal peoples on the development of an Aboriginal Health Reporting Framework.[217] Through the use of indicators permitting comparisons between Aboriginal and non-Aboriginal Canadians, the report is to provide information on the progress achieved and key outcomes. It is intended also to inform Canadians on current programs and expenditures, and provide a baseline against which new investments, service levels and outcomes could be tracked over time. This "report card" information is essential to the success of any wellness and healing strategy.

The strategy must include specifics about who will control its implementation, how to measure wellness, what goals can be established, when actions are to be implemented, and by what criteria the outcomes will be judged. It is essential to include a specific time frame

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216 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

217 Health Canada. (September 2004) Information: The 2003 Accord on Health Care Renewal. http://www.hc-sc.gc.ca/hcs-sss/medi-assur/fptcollab/2004-fmm-rpm/fs-if_01_e.html.

for implementing actions and evaluating outcomes, as well as a sustained and sufficient funding mechanism.

The Committee recommends:

93	**That, as a priority, the Canadian Mental Health Commission (see Chapter 16), with the full involvement of its Aboriginal advisory committee, develop a strategy for mental health wellness and healing among Aboriginal peoples.** **That the strategy set goals, including a timetable for implementation, and recommend ways to evaluate outcomes.** **That the strategy adopt distinct approaches for First Nations, Inuit and Métis.**

14.5 ACTION ON HEALTH DETERMINANTS FOR EACH GROUP

Key factors in the broader environment — income and social status, social support networks, education, employment, social and physical environments, personal health practices and coping skills, healthy child development, biology and genetic endowment, health services, gender and culture — are relevant to good mental health.

Witnesses emphasized that a successful strategy will rely on full recognition of the range of conditions or health determinants that contribute to the poor health status of Aboriginal peoples. They illustrated how key factors in the broader environment — income and social status, social support networks, education, employment, social and physical environments, personal health practices and coping skills, healthy child development, biology and genetic endowment, health services, gender and culture — are relevant to good mental health. But most importantly, they talked about how, if the positive effect of each of these determinants can be made available to Aboriginal people, many negative mental as well as physical health outcomes could be prevented.

14.5.1 Culture- and Group-Specific Approaches

Witnesses envisioned traditional healing, language and culture as critical in overcoming negative attitudes and behaviours.

As noted earlier, Aboriginal peoples are diverse. Even among those who identified themselves as North American Indians (almost 65%), Métis (30%) or Inuit (5%), there are many different cultural practices, relationships, languages, and social, economic, and geographical situations within Canada's jurisdictional boundaries.

For First Nations, the 2001 Census indicated that over half (52%) of North American Indians with legal status lived on reserves. Witnesses emphasized how the very existence of reserves affected the mental health of North American Indian populations, a fact frequently exacerbated by their remote location.

As James Morris, Executive Director, Nodin Counselling Services in northern Ontario, commented:

> *I do not need to talk about the environment in which these people live; they live in debilitating poverty in remote communities. It is the same story in any remote area where people are poor. The environment is the same in all First Nations communities. I never think of a reserve as the normal environment for First Nations people.*[218]

For Inuit, geographical location points to certain needs with respect to program and service delivery. Five of the largest Inuit communities (with populations from 1,500 to 3,000) are clustered above or near the 60th parallel in western territories and eastern provinces. The Committee was reminded that it was only within the last 50 years, as the federal government established a significant presence in the Arctic, that Inuit were moved away from seasonal camps and relocated into permanent settlements.

According to Jennifer Dickson:

> *During the 1950s, Inuit in seasonal camps and in smaller communities were compelled to resettle at other existing communities when church, health and government officials decided that their social and economic welfare would be improved by living in larger centres. However, this program seriously disrupted the historical and cultural organization of the people and had long-lasting negative consequences for resettled families.*[219]

For the Métis as well, history has determined their current status — particularly the fact that, to date, their relationship with other Canadians has not been governed by treaties or land claims. In 2001, almost one-quarter of all Métis lived in Alberta, and the province is unique in having Métis settlement legislation that delegates to them authority to develop limited bylaws and policies in specific northern areas. However, nearly 70% of the total Métis population across Canada live in cities (outside of specific settlements), together with more than seven in ten (73%) of those North American Indians who do not have legal Indian status.

Witnesses envisioned traditional healing, language and culture as critical in overcoming negative attitudes and behaviours. Tarry Hewitt called for community-based decisions about conventional or traditional healing practices, but noted that:

> *....acknowledgment of the efficacy of traditional practices to promote healing is critical to overcoming the habits of dependency and to restoring Aboriginal self-esteem and confidence in their own cultural imperatives.*[220]

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218 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

219 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

220 16 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/22evc-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

In a similar vein, Jennifer Dickson supported culturally relevant approaches:

> *Unique traditional knowledge and culture is central to Inuit health and well-being. Inuit wisdom and ways must be incorporated into all programs if we are to affect individual and community health positively.*[221]

14.5.2 Family and Community Supports

Many witnesses emphasized that strong families and communities are essential to achieve overall wellness. They acknowledged the need for individual choices, but stressed how collective social factors exert a major influence on many decisions that Aboriginal peoples make about their lives.

Bernice Downey observed how healthy families make strong communities:

> *When you talk about mental health, you look at healthy families. You see they have ways to support themselves, a sense of purpose in their life, and a job that they feel they can make a contribution to. They can undertake their ways of life and not be restricted by restrictions on hunting, as an example, so that they can teach those traditions to their youth and their youth then can go forward. That is what mental health is all about for communities.*[222]

Other witnesses stressed that caring social relationships and supportive networks provide stability for people and help them solve problems and deal with adversity. Individuals lacking a sense of control over their life circumstances have decreased overall well-being. Bill Mussell proposed a concept of "community of care" as one way to protect against potential problems:

> *I like the notion of "community of care." Our young people feel that they are homeless people even though they have a house with a roof, walls and so on. They have a house but not a home. Their caregivers are not there, their loved ones are not there, and the people they would like to have care about them are absent.*
>
> *The better question is this one: What do we need to do with limited resources to contribute to the creation of that community of care?*
>
> *I do not think you can buy it, but I certainly think you can do things to contribute to its development.*[223]

The fact that Aboriginal peoples frequently change their place of residence is a concern. It leads to a lack of continuity in social connections as well as the subsequent loss of a sense of

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221 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

222 21 April 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/13evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

223 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

community. Census data indicated that the on-reserve population was relatively stable, but one-third (33%) of the North American Indian population with legal Indian status in large cities moved every year. As well, 25% of the North American Indian population without legal Indian status and 23% of the Métis population moved each year — twice the mobility of non-Aboriginal people (14%).

14.5.3 Children and Youth

The population of all Aboriginal groups is much younger than the non-Aboriginal population.

The population of all Aboriginal groups is much younger than the non-Aboriginal population. Inuit have the youngest population, with a median age of only 20.6 years, compared to the non-Aboriginal population's 37.7 years. This means that 40% of Inuit are children under 15 years of age. Of the Métis population, 30% are children under 15 years of age. Of the North American Indian population, 25% of those with legal status and 35% of those without legal status are children under 15 years of age.

Setting up youth internships; creating youth employment opportunities; promoting traditional values and teachings; consulting with the Winnipeg Police Service and the RCMP; providing workplace safety education; and focusing throughout on suicide prevention.

Children are particularly affected by social supports, physical environments, family stability and socio-economic status. James Morris shared his experience and observations on the critical importance of adequate support for young people:

> *I know kids who are hungry. I know kids who are not well clothed. I know kids who have no place to sleep. I went to a place in one community, which consisted of just a little trailer. There were 18 people living in there, with three beds. Everybody had to take turns sleeping. If it was not the kid's turn to sleep that night, he did not go to school the next day. He had to go to bed when everybody else got up.*[224]

Gloria Laird, Co-Chair, Alberta Mental Health Board, Wisdom Committee, talked about the difficulties of having a large number of Aboriginal children and youth in the social service system in which only a tiny percentage of staff members are Aboriginal. She also suggested that a high percentage of child prostitutes in Alberta are Aboriginal and that they have special needs that are not met by the current system:

> *For a number of years I have been advocating for a holistic healing centre. That has not been supported. You can talk until you are blue in the face, but there is no change. The young people are saying that they want to go out to the country and they want to have elders present. They say they want to do sweats and they want to clean themselves up. They need something different. They need to get out of the cities.*

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[224] 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

> *Who will open a holistic healing centre for those young people who do not have a voice? These children are getting younger and younger, 10 and 11 years old. It is difficult to get out of that lifestyle if you are addicted to drugs such as crystal meth.*[225]

There was a strong plea to support young adults as they develop a greater understanding of the world and their place in it. Jason Whitford, Coordinator, Youth Council, Assembly of Manitoba Chiefs, recounted work in a range of important areas: setting up youth internships; creating youth employment opportunities; promoting traditional values and teachings; consulting with the Winnipeg Police Service and the RCMP; providing workplace safety education; and focusing throughout on suicide prevention. The broad goal was to encourage and promote the concept of youth involvement and youth leadership in creating change:

> *We are telling the youth if they do not like the way things are there are enough of them that they can take over their communities and re-create them the way they want to see them. Through volunteerism and youth councils, youth organizations, they can start to take ownership of the issues and create opportunities for the other youth around them. They want to see change in their own communities, but there are a lot of youth out there who just do not have the means to express themselves positively.*[226]

14.5.4 Socio-Economic Conditions

Witnesses identified a range of socio-economic conditions that have affected their overall health and well-being. In general, amelioration of income inequalities for Aboriginal peoples was linked to improved access to education and to employment that, in turn, affected access to housing, food and other physical and social necessities.

For too many Aboriginal people, unemployment or underemployment are prevalent factors contributing to poor health.

Factors such as housing and community infrastructure influence psychological well-being. It is particularly significant that Aboriginal households (Indian, Inuit and Métis) are much more likely than non-Aboriginal populations to live in housing below an acceptable standard of adequacy.

Among the Aboriginal groups, Métis reported the highest median income in 2000 at about $22,000, a level below that of the non-Aboriginal population by nearly $8,000. Various factors affect the ability of Aboriginal populations to generate income. For example, education is directly linked to employment opportunities, and the Aboriginal population with incomplete high school is almost twice as high as their non-Aboriginal counterparts. In addition, the youthfulness of the Aboriginal populations means that only about 40% of the Inuit are in the working-age population aged 25 to 65 years.

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[225] 9 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/21evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

[226] 31 May 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/16evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

Employment provides not only income for necessities like housing and food, but also a sense of identity and purpose, social contacts and opportunities for personal growth. For too many Aboriginal people, unemployment or underemployment are prevalent factors contributing to poor health. As Elsie Bastien testified, not only is employment limited, but, because of social assistance rules, individuals are restricted from participating in other meaningful activities:

> *Most of our people are unemployed because there is no work. Our unemployment rate is at 85 per cent. The community looked at funding people to take training so that they could then volunteer to work in some of the programs. However, at the beginning of this year, the federal government changed the Welfare Act to reflect, I believe, what the province has, and so many of those people who would have, could have, been doing some of the community work, because we do not have the dollars to pay them, now cannot do that because they have to be looking for gainful employment. They need to demonstrate that they have been seeking gainful employment before they get their welfare cheque at the end of the month.*[227]

Factors such as housing and community infrastructure influence psychological well-being. It is particularly significant that Aboriginal households (Indian, Inuit and Métis) are much more likely than non-Aboriginal populations to live in housing below an acceptable standard of adequacy (measured by houses in need of major repair) and suitability (measured in terms of crowding of the residents).

Larry Gordon reported that:

> *In many regions, housing shortages have reached crisis proportions in our area. The mental impact on families so crowded that people must sleep on the floors and in shifts cannot be underestimated in our region. Homeless people drift from relative to relative to find a spot for the night.*[228]

14.5.5 Gender

Current roles, behaviours, and power relations often place women in a doubly disadvantaged position — as women and as Aboriginal people.

To support the mental health of both men and women in Aboriginal communities, changes in practices and priorities are required. Several witnesses stressed the need for greater gender awareness and balance in families and communities as well as in organizational and governmental structures and actions.

Current roles, behaviours, and power relations often place women in a doubly disadvantaged position — as women and as Aboriginal people. Witnesses noted that the number, quality and effectiveness of services available to Aboriginal women and related supports to their children do not compare to those services provided to Canadians as a whole.

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227 9 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/21evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

228 21 April 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/13evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

But women were also seen as instrumental in effecting real change and successful outcomes for Aboriginal communities. Bill Mussell pointed out that strong women hold the key to their own mental health and that of their families and their communities. Jennifer Dickson stressed that:

> *Inuit women are truly the agents of change in Canada's Arctic. If motivated, included, franchised and supported, they can and will contribute substantially to strong, stable, healthy and happy communities.*[229]

14.5.6 Recommendation for Action

The Committee listened carefully as witnesses presented evidence related to key health determinants and concurred as to their centrality to mental health, whether of individuals, families, communities, or Aboriginal peoples in general. It agrees with the need for an action plan to focus on multiple determinants of health and on the complex interactions among them. Given the numerous root causes of the mental health problems of Aboriginal peoples, any strategy to address them must be based on clear evidence, both about particular problems and about the dimensions of effective measures to address them.

The Committee recommends:

9.1	**That the Canadian Mental Health Commission (see Chapter 16), in consultation with its Aboriginal advisory committee, develop, as an integral component of the wellness and healing strategy for mental health, a plan that would:** • **identify key health determinants;** • **assess the influence of these determinants on mental health;** • **detail measures for implementation; and** • **establish timelines and funding levels needed to promote wellness and healing.**

14.6 ACTION ON JURISDICTIONAL RESPONSIBILITIES

The Committee heard frequently that lack of clarity on the jurisdictional responsibility for Aboriginal peoples is one of the major challenges in building a coherent, integrated system to plan and deliver mental health and mental wellness services.

First Nations who are registered Indians on reserve are provided with a number of programs and services relevant to mental health; but when these same people leave the reserve, the

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[229] 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

situation changes. Lorraine Boucher, Director of Health Programs, North Peace Tribal Council, observed that:

> *First Nations people are always being thrown back and forth like a political football concerning accessing services. When we are on reserve, we are under the federal government; when we are off reserve, we are under the provincial government.* [230]

For the Inuit, the situation is similar. Onalee Randell emphasized that, in the unresolved dispute over jurisdictional responsibilities, it is the people who need services that are suffering:

> *There continues to be discussions around responsibility — whether the federal, provincial or territorial governments have responsibility. The outcome is that those discussions are taking precedence over the delivery of services to Inuit communities and preventing those well-needed services from being delivered.*[231]

Lack of clarity on the jurisdictional responsibility for Aboriginal peoples is one of the major challenges in building a coherent, integrated system to plan and deliver mental health and mental wellness services.

Like North American Indians without legal status, Métis face mental health concerns comparable to those of First Nations and Inuit but are continually battling for jurisdictional recognition within the Canadian federation. The federal government does not acknowledge specific responsibilities for Métis or non-status Indians, while the provinces and territories are reluctant to seek legal clarification of the issue. Many Métis simply want clarification about the jurisdiction applying to them, either federal or provincial, so that access to needed services can be made easier.

> *Under the jurisdiction regarding Metis, they need an increase in services provided to them. They also need to resolve the jurisdictional situation so that they are no longer denied access to Aboriginal federal or provincial mental health and related programs. —Donna Lyon*[232]

14.6.1 Defining the Federal Role

Currently, all levels of government are ambivalent about their responsibilities with respect to the health of Aboriginal peoples. The *Constitution Act, 1867*, which provided (in section 91 and 92) a legislative division of powers between the federal Parliament and provincial legislatures, allowed for a division of responsibility for Aboriginal peoples into categories, some of which are accorded status through federal recognition while others are not.

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230 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

231 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

232 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

For the federal government, the *Indian Act* has provided a baseline for services to registered status Indians on reserve and to certain Inuit. Following a 2004 commitment to develop an Inuit Secretariat within the Department of Indian and Northern Affairs, the federal government has begun to take a more publicly identified role in its approaches to Inuit-specific issues. Since 1985, except under programs aimed at the general Canadian population, Métis and non-status Indian issues have been dealt with by a federally appointed interlocutor for Métis and non-status Indians rather than by a specific federal department.

Provincial and territorial governments are reluctant to provide Aboriginal-specific funding or services, fearing that they will be perceived as accepting jurisdictional responsibility. This pervasive ambivalence is particularly serious with respect to mental health, where the applicable programs and services must certainly encompass education, housing, employment, and social assistance, as well as health — all areas generally accepted as provincial/territorial responsibilities.

There was no ambivalence among the witnesses who appeared before the Committee and called for a clearly defined relationship with the federal government. The Canada-Aboriginal Peoples Roundtable process in 2004 was seen as a useful beginning for First Nations, Inuit and Métis in their call for self-determination based on indigenous rights.[233] At the end of May 2005, the organizations representing various groups signed a number of statements that outlined specific measures to define further relationships with the Government of Canada.[234]

Witnesses spoke to the Committee of a new special relationship with the Government of Canada outside the current, often multiple-departmental interactions. Irene Linklater stressed the need to re-establish the special relationship with the Crown. She went on to say that First Nations want:

> *...a direct relationship to, if not the Prime Minister then to the Privy Council; to primary decision-making bodies that have a fiscal arrangement directly with First Nations, and a direct First Nations-to-federal government relationship, a nation-to-nation relationship...*[235]

14.6.2 Focusing Federal Departmental Efforts

At the federal level, responsibilities for the areas that determine positive mental health for Aboriginal peoples fall under the mandates of several departments. The picture is one of extreme fragmentation as multiple departments offer selective programs or services to particular groups of Aboriginal peoples. In most instances, the provision is exclusively to First Nations on-reserve; in others, only to First Nations off-reserve; some include Inuit and a few have a broader Aboriginal focus.

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233 Canada-Aboriginal Peoples Roundtable. Final Roll-Up Report (by facilitators). http://www.aboriginalroundtable.ca/sect/ffr/index_e.html.

234 Indian and Northern Affairs Canada. (31 May 2005) News Release, "Federal Ministers and National Aboriginal Groups Participate in Joint Policy Retreat." http://www.ainc-inac.gc.ca/nr/prs/m-a2005/2-02665_e.html.

235 1 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/16evc-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

In 2005, 16 federal departments and agencies offered programs for Aboriginal people with total expenditures of approximately $9.1 billion. Approximately two-thirds of all funds (about $6 billion) are spent by Indian and Northern Affairs Canada. Health Canada accounts for close to $2 billion, while other departments and agencies account for slightly more than $1 billion.[236] To date, there are no estimates of the total federal funding spent on mental health, mental illness and addiction among Aboriginal peoples.

Except for certain obligations specified in the *Indian Act* and administered by the Department of Indian and Northern Affairs, the federal government has permitted the development of a different foundation for each set of programs and services offered to Aboriginal peoples. Neither the *Constitution Act, 1867* nor the *Constitution Act, 1982* provide legislative authority to, or impose legal obligations on, the relevant federal departments or agencies.

At the federal level, responsibilities for the areas that determine positive mental health for Aboriginal peoples fall under the mandates of several departments. The picture is one of extreme fragmentation as multiple departments offer selective programs or services to particular groups of Aboriginal peoples.

The need to deal with several departments is viewed as a major, crippling impediment by Aboriginal peoples. For First Nations, the split of social programs and subsequent funding between two departments has created a gap in health and in the relationship of First Nations with the Crown and the Government of Canada:

To date, there are no estimates of the total federal funding spent on mental health, mental illness and addiction among Aboriginal peoples.

> *I would point out that there is a gap…in the relationship between the constitutional arrangements as set out by Canada, having established an administrative body called Indian Affairs, whose powers in this regard are now delegated to a federal department called Health Canada, to FNIHB, and that structure filters the money. —Irene Linklater*[237]

For the Inuit, Onalee Randell emphasized that, because there are so many departments involved, departmental silos are reinforced, perpetuating unresolved disputes over jurisdictional responsibilities:

The need to deal with several departments is viewed as a major, crippling impediment by Aboriginal peoples.

> *It is also resulting in poor communication and coordination between not only health service providers from one region to another or from one community to another, but also from the intergovernmental departments. The housing people do not ever want to talk about how housing impacts mental wellness. The education people do not ever want to talk about how to revise or change*

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236 Indian and Northern Affairs Canada. 2005-06 Estimates: Report on Plans and Priorities, "Federal Partners." http://www.tbs-sct.gc.ca/est-pre/20052006/INAC-AINC/pdf/INAC-AINCr56_e.pdf

237 1 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/16evc-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

curriculum to assist students to have the self-esteem and coping skills they need.[238]

For Métis, the problem is that there is simply no departmental focus or concentrated governmental attention. Neither Indian and Northern Affairs Canada nor Health Canada assume specific responsibility. According to Gloria Laird, however, Co-Chair, Alberta Mental Health Board, Wisdom Committee, people are beginning to look at ways to develop a departmental focus in relation to the health and health service needs of Métis people.[239]

14.6.3 Recommendation for Action

The Committee recognizes that if any strategy and action plan are to be successfully implemented, this jurisdictional ambivalence needs to be sorted out, or at least replaced with clear statements of where responsibilities lie. The present reality is that Aboriginal peoples are very mobile and cross jurisdictional boundaries frequently. Moving on and off reserve as well as between provinces and territories should not occasion a loss of continuity in the delivery of services which can lead, in turn, to a loss of the programs essential for mental health.

If any strategy and action plan are to be successfully implemented, this jurisdictional ambivalence needs to be sorted out, or at least replaced with clear statements of where responsibilities lie.

Moving on and off reserve as well as between provinces and territories should not occasion a loss of continuity in the delivery of services which can lead, in turn, to a loss of the programs essential for mental health.

The Committee was told that all levels of government have consistently denied full responsibility for the deterioration of the overall health status of Aboriginal peoples. Such denial has led to the offloading of responsibilities, obscuring of factual information, and failure to develop methods for assessing progress toward better health, including mental health.

An unprecedented level of both federal leadership and intergovernmental collaboration is necessary to address the epidemic of mental health problems, including suicide and addictions, in Aboriginal communities.

Witnesses indicated clearly that they want a more direct relationship with the Crown, through the Government of Canada, that enables them to take direct responsibility for their own health. But they want to do this as part of a relationship with the Government of Canada that recognizes the ability of Aboriginal peoples to control their lives if provided with sufficient resources and support.

The Parliament of Canada and the federal government have long-term responsibilities for the state of well-being of all citizens of Canada, including all Aboriginal peoples. An unprecedented level of both federal leadership and intergovernmental collaboration is necessary to address the epidemic of mental health problems, including suicide and addictions, in Aboriginal communities. Beyond the work to be undertaken by the proposed

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238 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

239 9 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/21evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

Canadian Mental Health Commission, it is imperative that the federal government initiate action immediately to address the mental health needs of Aboriginal peoples.

The Committee has considered several potential federal foci that would complement and support the work of the proposed Canadian Mental Health Commission. Despite parliamentary oversight provided through standing committees in both Houses and through occasional reports by the Auditor General, Aboriginal peoples' issues have not been examined sufficiently rigorously or continuously by Parliament. One option might involve the establishment of a Parliamentary Officer, similar to the Auditor General or the Commissioner of Official Languages, who would report directly to Parliament (rather than to the federal government or to an individual minister).

A second option, based on the Prime Minister's initiatives for the Canada-Aboriginal Peoples Roundtable process, would be to establish a permanent structure similar to the National Round Table on the Environment and the Economy. Constituted as an independent advisory body, this National Round Table functions as a coalition builder, working to reconcile the often opposing governmental, industry, and community positions.

The Committee believes, that the most pressing need is to coordinate federal efforts directed at improving the health and well-being of Aboriginal peoples in Canada.

The Committee believes, however, that the most pressing need is to coordinate federal efforts directed at improving the health and well-being of Aboriginal peoples in Canada. The establishment of a Cabinet Committee on Aboriginal Issues and a secretariat at the Privy Council Office, combined with the 2003 commitment to develop a report card on Aboriginal peoples, opens the door to greater direct recognition of the federal relationship with all Aboriginal peoples.

The Committee recommends:

95	**That the Government of Canada create an interdepartmental committee composed of deputy ministers in departments with responsibility for Aboriginal peoples, chaired by the Privy Council Office.** **That the interdepartmental committee prepare a report to be tabled in Parliament every two years on the impact of the work of these departments on the wellness of Aboriginal peoples, including but not limited to their mental wellness.** **That this Aboriginal wellness report include an inventory of all federal programs and services specific to each group of Aboriginal peoples, with information on spending and the impact on actual health outcomes achieved, including but not limited to mental health outcomes.**

That the interdepartmental committee support working groups composed of First Nations, Inuit and Métis representatives to provide information, advice and verification of the report.

14.7 ACTION ON DELIVERY OF PROGRAMS AND SERVICES

Programs and services that are designed to maintain health, prevent ill-health, and/or restore health and function, also constitute a determinant of health for Aboriginal peoples. As noted earlier, specific federal programs and services relevant to the mental health of Aboriginal peoples are provided primarily to First Nations clients living on reserve. Often, by extension, they are provided also to Inuit clients, but seldom to non-status Indian and Métis clients.

Of the 16 federal departments and agencies that offer programs for Aboriginal people, primary responsibility rests with Indian and Northern Affairs Canada and Health Canada. Indian and Northern Affairs Canada is responsible for the administration of the *Indian Act* and is the major provider of basic services such as education, social assistance, housing, and community infrastructure to status Indians on reserve, and some Inuit communities. With respect to specific health services, Health Canada is responsible for the provision of primary care through nursing stations and health centres to First Nations and Inuit clients on reserves and in many remote and isolated communities. The Non-Insured Health Benefits Program offers assistance with drugs, crisis intervention and mental health counselling to eligible First Nations and Inuit clients regardless of residency when no other insurance coverage is available.

Witnesses emphasized a number of underlying premises essential to successful outcomes from any program and service relevant to mental health, including: community authority and control; cultural accommodation; and equity of access. Incorporation of these elements into program and service delivery would help build what Bill Mussell referred to as "promising practices":

> *We talk about our weaknesses, problems and issues, but seldom do we ever talk about our resources and what our strengths are and the good ways of our life. What are the promising practices that we live with? I tend to hesitate to use "best practices" because I think there is so much that we do not know. If we were to buy into the notion of best practices, I think we would be cutting ourselves off before we had a chance to truly identify, explore and discover what truly works.*[240]

14.7.1 Community Authority and Control

Most witnesses testified that community authority and control over programs and services is essential to successful outcomes. They insisted that Aboriginal communities must take control of their own destinies through oversight of the design of mental health programs

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[240] 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

and services, their delivery and cultural appropriateness. Valerie Gideon argued that unless First Nations have a sense of ownership and control over a comprehensive set of mental wellness programs, any new investment or initiative would inevitably work against itself.

Others stressed the need for capacity building to identify the strengths and expertise within each Aboriginal family and community. For Bill Mussell, "the foundation of the approach is to build community capacity that is reliable, safe and helpful within the context of regional and provincial support." He indicated:

> *Capacity needs to be built at all levels of the system: the individual; family communication and problem solving; peer-to-peer helping; support group models that reflect the reality of community networks and existing relationships; peer and other professionals to help staff at the community level who offer services based in the range of mainstream cultural and complementary approaches of healing and helping; regional resources, including highly skilled professionals such as psychologists willing to bring their skills to engage in a creative and collaborative process to develop new programs and services; and provincial services that provide a high level of specialized services to support the capacity-building needed in the communities.*[241]

Witnesses insisted that Aboriginal communities must take control of their own destinies through oversight of the design of mental health programs and services, their delivery and cultural appropriateness.

Ian Potter, Assistant Deputy Minister, First Nations and Inuit Health Branch, Health Canada, also recognized that communities are seeking empowerment and control:

> *I am absolutely convinced that better health outcomes will not be achieved unless we can support the communities in taking a more active role. Our strategy is to try to work with the provinces and the communities, using the federal government resources, to see if we can design a health system in which communities can play that role. I do not think that we will get the results, as technically proficient as we may be, unless we can build a health system that is seen to be driven by the community, supported by the community and, often, delivered by community members.*[242]

With regionally identified, regionally based and regionally delivered programs and services, Aboriginal peoples report difficulties in achieving full consultation and participation.

He also noted that Health Canada is pushing for greater integration of federal services with provincial services to reduce duplication and problematic overlap, arguing that:

> *Most of the services we fund are delivered by First Nations and Inuit. Part of that process is to support them so that they can play an active and essential role*

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241 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

242 20 April 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/13eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

> *in the fundamental health care system in Canada, which is provincial or territorial.*[243]

Aboriginal peoples raised some concerns, however, about being pushed into the provincial (often regionally based) sphere. With regionally identified, regionally based and regionally delivered programs and services, Aboriginal peoples report difficulties in achieving full consultation and participation.

As Valerie Gideon pointed out:

> *Especially in provinces where much of the decision-making is devolved to fairly independently operating regional health authorities, First Nations communities have to take on their responsibility to push the regional health authorities to be accountable to them for the type of services they provide to their members. The reality is that they do not have the capacity for that. Very few of the regional health authorities reach out to First Nations communities in their areas to develop relationships.*[244]

Onalee Randell emphasized that regional funding is not supportive of community-based programs:

> *We seem to be in an era of federal funding that is not community-based; it is regional funding involving specific communities. In areas of mental wellness, this funding is insufficient. How do you define which community requires mental wellness programming? Is it the community that does not have the suicides or the community that has had four, five, six or seven suicides in that year?*[245]

14.7.2 Cultural Accommodation

Witnesses called for cultural awareness training and orientation for mental health staff as well as other service providers, including teachers, police, and officials for social services and children's services.

Witnesses called for access to culturally appropriate health care and services that recognize the internal cultural diversity, even within each group. They called for cultural awareness training and orientation for mental health staff as well as other service providers, including teachers, police, and officials for social services and children's services.

Elsie Bastien stated that understanding and accepting the diversity of Aboriginal peoples was central:

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243 20 April 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/13eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

244 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

245 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

> *Mental health providers can only create an environment of culture safety for Aboriginal people if they have been trained to understand and accept the cultural, linguistic, tribal, geographical, economic, political and community context of the various Aboriginal communities. Failure to grasp the significance of these contextual factors often leads to stigmatization, misdiagnosis, and inappropriate treatment.*[246]

Tarry Hewitt and others provided a recurring focus on traditional healing practices as a significant factor in moving forward:

> *Healing circles, culture-based and guided by an experienced, and in our case, academically trained Aboriginal who engages in traditional healing, are far more than a cosmetic overlay to "group sessions." They are rooted in ceremonies and traditions that can only be performed by those from the Aboriginal community who possess a depth of knowledge and who are recognized within that community as being capable of leading healing circles.*[247]

Although witnesses agreed that more authority should be delegated to Aboriginal communities to customize services and foster solutions that are more culturally appropriate, they recognized some challenges. Tarry Hewitt acknowledged that supporting traditional skills:

> *involves not only overcoming a non-Aboriginal bias in favour of conventional treatments and methods of delivery, but also the challenge of Aboriginal perceptions that, as a result of decades of paternalistic intervention, non-Aboriginal practices are superior.*[248]

As Sheila Levy pointed out, cultural traditions need to be blended with social realities:

> *Looking backward in rose-coloured glasses has not helped. Inuit want the best of both worlds in which they live. Many Inuit with whom I work and whom I know well have pointed this out to me. They want evidence-based methods and approaches integrated with Inuit beliefs, ways and cultural knowledge.*[249]

Clearly, the differences in identity, in size and in geographical location of each group must be factored into any mental health strategy. Officials from Correctional Service Canada were asked if programs and services for Aboriginal offenders considered adjustment issues: for example, an individual who displays signs of mental health problems may simply be experiencing social adaptation problems arising from the fact that he or she comes from a different cultural and geographic background. Dr. Michael Bettman of Correctional Service

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246 9 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/21evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

247 16 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/22evc-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

248 16 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/22cv-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

249 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

Canada indicated that the issues involved are very complex and good solutions are difficult to find:

> *If you are looking at specific cultural treatments, and you are adding the dimension of urban versus rural, it becomes more complicated. That is why we embarked on, not so much recreating but building from the ground up, many of our programs for Aboriginal populations specifically — designed by Aboriginal people, often delivered by Aboriginal people for the overrepresented Aboriginal population in our federal system.*[250]

14.7.3 Equity of Access

Although the federal government asserts that there are reasonably comparable levels of service for Aboriginal peoples throughout the country, many witnesses insisted that this is not the case.

Although the federal government asserts that there are reasonably comparable levels of service for Aboriginal peoples throughout the country, many witnesses insisted that this is not the case. They described an overall patchwork of programs and services for Aboriginal peoples depending on whether they are Indian, Métis, or Inuit, and whether they live on or off reserve, at a remote northern or a southern urban setting, in a specific province or territory. Furthermore, witnesses argued that providing provincial services comparable to those available to the general population to people whose overall health and wellness status is so much lower does not make sense. To achieve real health comparability, programs and services must be designed to enhance and build positive health status among Aboriginal peoples specifically.

The Committee was reminded by Donna Lyon that the Métis are generally excluded:

> *Within the Metis Centre, some 30 per cent of the Metis people make up the target of our Aboriginal population [but] they are not included in many of the initiatives available to First Nations people and possibly Inuit people as well. They are not included in the National Indian Health Board program. They have no access to the National Native Alcohol and Drug Abuse Program.*[251]

To achieve real health comparability, programs and services must be designed to enhance and build positive health status among Aboriginal peoples specifically.

Even for First Nations, there are problems with continuity depending on whether an individual is on reserve or off reserve in an urban setting. Irene Linklater pointed to residency requirements for reserve benefits:

> *There is a residency issue there, that once you have been away in hospital for three months, then you no longer have that benefit; you must then go to the province. There are other complications that can arise, such as if you go away to school, or you leave and then you have palliative care requirements, you*

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250 23 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

251 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

cannot go back to your community because medical services does not pay for your trip back home to die with dignity.[252]

Within each jurisdiction, the delivery of health services to Canada's Inuit population varies with place of residence. Inuit argue that there are differences between those who live in the territories, where the federal government still assumes some jurisdiction, and the provinces with larger Inuit populations such as Quebec or Newfoundland and Labrador where the federal government sees a provincial obligation to provide northern services. As Onalee Randell explained:

> *The First Nations and Inuit Health Branch provides prevention and promotion programs and in some cases, limited care and treatment programs to Inuit communities through the two territorial governments: for Inuit living in Nunavut and Inuvialuit, through the Nunavik Health and Social Service Board for Inuit in Quebec, and through the Labrador Inuit Health Commission for Inuit in Labrador. In Nunavik, for example, in northern Quebec, if someone requires significant mental health services, they are transported by Medivac to Montreal, to a provincial hospital, where they have developed a partnership or an agreement. In fact, Nunavik has one bed dedicated for Inuit in Montreal for mental health services.*[253]

14.7.4 Recommendation for Action

The Committee recognizes the need for "outside the box" thinking and innovative ideas that lead to programs with clear goals and clear ways of measuring progress or the lack of it. It is looking for some specific results from the $200 million allocated for an Aboriginal Health Transition Fund following the September 2004 special meeting of the Prime Minister, First Ministers and Aboriginal leaders.[254] This federal fund is to enable governments and communities to devise new ways to integrate and adapt existing health services to better meet the needs of Aboriginal people.

The Committee recognizes the need for "outside the box" thinking and innovative ideas that lead to programs with clear goals and clear ways of measuring progress or the lack of it.

The Committee agrees with the need for a seamless system to promote well-being, not only for First Nations and Inuit, but for all Aboriginal people.

The Committee agrees with the need for a seamless system to promote well-being, not only for First Nations and Inuit, but for all Aboriginal people. The Committee is aware that many First Nations have accepted responsibility for the direct delivery of health care services. It further

The Committee believes that programs and services delivered to all Aboriginal peoples will lead to more successful outcomes if the principles of cultural accommodation and equity of access are respected.

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252 1 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/16eve-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

253 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

254 Government of Canada. (September 2004) Commitments to Aboriginal Health. http://pm.gc.ca/grfx/features/23-fmm_e.pdf.

recognizes the need for greater community involvement in the design and implementation of all programs and services directed to Aboriginal peoples, including, where possible, direct community authority and control over them. Moreover, the Committee believes that programs and services delivered to all Aboriginal peoples will lead to more successful outcomes if the principles of cultural accommodation and equity of access are respected.

The Committee does not expect the federal government to deliver all the required programs and services, but it does expect it to live up fully to its responsibility to ensure their provision. The federal government can do this either through direct delivery or by providing funding to the provinces specifically earmarked for Aboriginal peoples on a per capita and health status basis. Regardless of who is involved in the delivery of needed programs and services, the key is to have clear lines of authority and to monitor outcomes carefully. Adequate checks and balances and appropriately objective evaluation measures must be in place.

The Committee acknowledges that the logical consequences of the preceding arguments and evidence about jurisdictional responsibilities and program and service delivery strongly suggest the need for a completely different model of governance of the broad affairs of Aboriginal peoples in Canada. This new model must recognize that the time is ripe for serious consideration of a mechanism to include Aboriginal peoples in the decisions that affect their lives. The Committee also knows, however, that this new model cannot be a simple administrative reconfiguration. Nor can its development be proposed in the context of a report whose primary focus is the mental health and well-being of Canadians in general.

The Committee does not believe, therefore, that it is appropriate to propose any new entity or structure solely on the basis of the testimony heard during this mental health study.

The Committee does not believe, therefore, that it is appropriate to propose any new entity or structure solely on the basis of the testimony heard during this mental health study. It is prepared, however, to add its voice to support further work on the issues of governance and of administration for Aboriginal peoples. In particular, it acknowledges the need for greater autonomy for Aboriginal peoples in the design and delivery of programs and services that meet the needs identified by their communities.

At this time, then, the Committee recommends:

96 **That the Government of Canada work closely with the provinces/territories and representatives from the different Aboriginal communities to develop programs and services deemed necessary by Aboriginal peoples.**

That criteria for the design and delivery of identified programs and services take into account the importance of enhancing community involvement, and of ensuring cultural accommodation and equity of access.

That any delivery mechanism for these programs and services include ongoing oversight and public evaluation of outcomes by the funding body.

That the criteria for funding and accountability provisions be made public.

14.8 SPECIFIC INITIATIVES

14.8.1 Renewal of the Aboriginal Healing Foundation

Many witnesses stressed the need to build on the efforts of the Aboriginal Healing Foundation and called for its long-term renewal. The Aboriginal Healing Foundation was established in 1998 with a 10-year mandate to address issues of physical and sexual abuse related to residential schools.[255] It has a special place as the first national Aboriginal organization representative of all groups working on Aboriginal-initiated and Aboriginal-implemented community projects. According to Gail Valaskakis, it played a critical role in providing partnerships, in identifying and filling the gaps in services, and in involving survivors and those who are intergenerationally affected.[256]

Representatives of First Nations and Inuit spoke about the need for long-term renewal of the Foundation's funding in order to expand and sustain community healing projects. For Shean Atleo, Chief A-in-chut, B.C. Regional Chief, its funding of healing efforts at the community level were crucial to increased emotional wellness in his community:

> *Through the 1990s, we saw a decline in suicide attempts and completions amongst the Nuu-chah-nulth. While there is no one factor that we can point to, I know that the work of the Aboriginal Healing Foundation was tremendous for our people. The foundation allowed for community-based design and delivery of healing.*[257]

For the Inuit, although late in coming to the process, the programs that resulted from the Aboriginal Healing Foundation filled a gap:

> *Inuit reviewing the Aboriginal Healing Foundation program see the need to expand it, to have it not only focus on residential schools and the negative impact of those schools relating to abuse but also the negative impact relating to language loss, cultural loss and the loss of parenting skills. This information is from Inuit who have provided information that they were not abused in residential schools; they believe the schools were a positive experience. However,*

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255 Aboriginal Healing Foundation. http://www.ahf.ca/newsite/english/about.shtml.

256 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

257 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

> *they did lose their language. They feel some loss of culture. —Onalee Randell*[258]

The Foundation's funding ends in 2007 and, for many groups, this constitutes another example of the instability created by short-term funding. By the time that communities develop the capacity to apply for funding through the Foundation, none will be available:

> *For the first three years of that funding, communities tried to figure out what they needed and how to implement it, and even to get assistance with writing the proposals, which the Aboriginal Healing Foundation provided. By the time initiatives with three- to five-year timelines are operational in communities, the funding has run out. It is hard to get qualified staff to give up permanent jobs to go into a project that may end in two years. —Onalee Randell*[259]

Gail Valaskakis confirmed that the Inuit were late in accessing the programs of the Aboriginal Healing Foundation. She also noted that:

> *Metis have been even more difficult to reach and are a target. Many areas of society that are invisible to all of us, such as the homeless and the incarcerated, have been difficult to reach as well...*[260]

Data from two studies related to the costs of abuse and the value of healing were used by Valaskakis to provide evidence that "healing is cost effective, personally effective and socially effective." According to the Canadian Incidence Study of Reported Child Abuse and Neglect, child abuse is extremely costly and when "applied to the residential school issue, it shows that Canadian society pays about $440 million per year on incarceration, social services, special education and health."[261]

The second study cited by Valaskakis looked at healing in relation to incarceration on the Hollow Water Reserve. It found that healing is more cost-effective than incarceration, and actually lowers its rate:

> *For every $2 spent on the community holistic healing circle program at Hollow Water, the federal and provincial governments save $6 to $16 on incarceration fees. That is a conservative estimate that was done by holding the cost of the system constant and adding the cost of one person to the system.*[262]

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[258] 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

[259] 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

[260] 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

[261] 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

[262] 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

The Aboriginal Healing Foundation is credited with providing the type of integrated approach that has a better chance of working than the stove-piped, or silo-structured, model currently in existence. As Gail Valaskakis testified:

> *To date, the Aboriginal Healing Foundation has invested $437 million in community-based projects, ranging in type from awareness and prevention to actual healing services, including long-term healing services in residential treatment in trauma centres and programs for addiction.*[263]

She called for support for the Aboriginal Healing Foundation on a long-term basis:

> *An endowment of $600 million would support a 30-year healing strategy with a 2.5 per cent inflation rate and a 5 per cent return on that investment. Thus, $28.7 million per year would be available for community-funded projects. This would mean that by year 30, the Aboriginal Healing Foundation would have invested $1.2 billion in healing.*[264]

The Committee commends the work done by the Aboriginal Healing Foundation and agrees with those who call for a long-term commitment to its work. It recognizes the need to continue to address the legacy of abuse and the intergenerational and other impacts of social, psychological, cultural and spiritual injuries. It supports the goals of acknowledgement, redress, healing and reconciliation.

The Committee recommends:

97	**That the Government of Canada renew the mandate of the Aboriginal Healing Foundation and provide funding for another three years.** **That, on a priority basis, the Canadian Mental Health Commission (see Chapter 16) and its Aboriginal advisory committee undertake an evaluation of the efficiency and effectiveness of the Aboriginal Healing Foundation.** **That the results of the assessment include recommendations concerning the future of the Aboriginal Healing Foundation and be made public.**

14.8.2 Increase of Health Human Resources

All witnesses acknowledged that mental health and the prevention and treatment of mental illness depend upon integrated, interdisciplinary care from a variety of health care providers. In Aboriginal communities, the acute shortage of family physicians, nurses, psychiatrists,

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263 21 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/23evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

264 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

psychologists, social workers and other professionals seriously affects the delivery of appropriate care and services.

Many emphasized the need for mental health professionals who are themselves Aboriginal, or at least are knowledgeable about Aboriginal cultures. Arnold Devlin recounted a story of how psychiatrists educated and oriented to a different culture and life experience reacted to Aboriginal peoples living in northern Ontario:

> *At one time psychiatrists in the Nishnawbe-Aski area were educated in Scotland and England. They would arrive from the University of Toronto to work in the area. They classified people with many strange multiple personality disorders and exotic mental illnesses. One time I spoke to a lady after she had seen the psychiatrist and asked what she had said to him. She said that she had simply told him about her life and he gave her medications to take. That is the reality and, often, the worldview and the sense of values and beliefs is very different so the psychiatrist's paradigm missed it all together and did not click on what was happening to that person.*[265]

Many emphasized the need for mental health professionals who are themselves Aboriginal, or at least are knowledgeable about Aboriginal cultures. Providers who are Aboriginal can counter cultural biases that can affect diagnoses.

According to Rob Wipond, providers who are Aboriginal can counter cultural biases that can affect diagnoses. In refuting the claim that Aboriginal communities suffer significantly higher rates of mental illness, he asserted:

> *Ample research has shown that culture, lifestyle and spiritual difference are crucial factors in diagnoses and forced treatment. If you start seeing gods and demons and believe you are approaching a mystical breakthrough, it is not at all likely that a psychiatrist is going to support your exploration. He is going to call you "delusional," probably "schizophrenic" and tranquilize you.*[266]

Several witnesses emphasized the need for innovation in addressing the shortages of Aboriginal people in the mental health field, pushing for thinking "outside the box."

The number of Aboriginal workers actually working in the field of mental health, and their particular concerns, have not been fully quantified. For example, one Aboriginal psychiatrist, Cornelia Wieman, who returned to her Six-Nation reserve to practise medicine, found that the community could not afford to pay her a salary commensurate with her training and expertise because it lacked the money to do so.

Dr. Arthur W. Blue noted that the Native Psychologists of Canada is a small organization with less than 20 members. He identified the need for a supportive institution responsible for training native clinical psychologists to achieve successes similar to the movement "from

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265 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

266 6 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/18eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

51 native physicians 20 years ago to 250 today." He went on to emphasize the important role for psychologists:

> *It is not only treatment but it is also prevention. Not only do they do psychometrics, psychotherapy, group psychotherapy, abuse treatment, both physical and substance, they are the best educated mental health professionals available in Canada, and should be working hand in glove with mental health workers, social workers, physicians and the band council.*[267]

Many Aboriginal people do not succeed in education and in pursuing careers as health workers. Several witnesses emphasized the need for innovation in addressing the shortages of Aboriginal people in the mental health field, pushing for thinking "outside the box." Tarry Hewitt described a legal training program for 10 students in Nunavut at Akitsiraq Law School in collaboration with the University of Victoria Law School, the University of Ottawa, the Government of Canada and the Government of Nunavut. She also mentioned the collaboration of the University of Cape Breton with First Nations communities in Nova Scotia to bring the university classroom to the communities:

> *Some of the obvious benefits to the communities include not having to leave home and family responsibilities to pursue post-secondary education and the ability to be educated in familiar versus intimidating surroundings. This leads to higher rates of retention. The educational institution benefits from this collaboration by giving visiting professors a chance to become more knowledgeable about First Nations communities and customs.*[268]

Debbie Dedam-Montour, Executive Director, National Indian and Inuit Community Health Representatives Organization, pointed out that the training for a community health representative (CHR) has changed as part of the health transfer process from one offered by Health Canada to one under band jurisdiction. She noted that: "Some colleges have CHR programs, such as the course at Portage College. Alberta and Manitoba offer courses but they are fragmented."[269] The current goal is to set up core competency training programs for the CHR in each of the provinces.

The issue of accreditation, of determining who is authentic and qualified to provide effective healing, was also addressed by Tarry Hewitt:

> *There is capacity within the Aboriginal communities to identify men and women who engage in traditional healing practices, who routinely seek guidance from elders and medicine men and women and who would be appropriate facilitators of healing circles and other traditional methods. Structures already*

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[267] 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

[268] 16 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/22evc-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

[269] 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

exist within the Aboriginal communities to vet the recognized ability of healers who would provide services in an accountable manner.[270]

The accreditation process is important for traditional healers who seek funding by Health Canada as health workers in Inuit and First Nations communities. According to Ian Potter, some system of standardization is needed:

> *We have some limitations with respect to funding traditional medicine because there is no system in place that defines who is a traditional medicine specialist. In other countries — and it is something we have tried to encourage First Nations and Inuit people in Canada to look at — the people who practice traditional medicine have organized themselves to certify who is a legitimate provider of these services. So far, we have not been able to achieve that. There is a difficulty, as liability issues arise; if we pay for something, we should know what standard we are paying for.*[271]

The Committee knows that successes in the area of Aboriginal health human resources have been achieved over the last few decades. It is aware of the efforts of both Health Canada's Indian and Inuit Health Careers program and the National Aboriginal Achievement Foundation. It also recognizes the positive step represented by the announcement of $100 million for an Aboriginal Health Human Resources Initiative as a result of the September 2004 special meeting of the Prime Minister, First Ministers and Aboriginal leaders.

The Committee believes that a special effort must be made to increase the number of Aboriginal people pursuing health care careers in the mental health field. Culturally sensitive approaches for training and retaining Aboriginal individuals as psychiatrists, psychologists, mental health nurses, social workers and others are needed urgently.

The Committee believes, however, that a special effort must be made to increase the number of Aboriginal people pursuing health care careers in the mental health field. Culturally sensitive approaches for training and retaining Aboriginal individuals as psychiatrists, psychologists, mental health nurses, social workers and others are needed urgently.

The Committee recommends:

98	**That the Government of Canada work with the provinces and with universities and colleges to establish clear targets for Aboriginal health human resources.** **That the Government of Canada finance specific access for Aboriginal students seeking careers in mental health.**

[270] 16 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/22evc-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

[271] 20 April 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/13eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

That the Government of Canada increase its financial and social support for Aboriginal students engaged in these studies.

14.8.3 Suicide Prevention

The rates of suicide among Aboriginal peoples are significantly higher than for the general population in Canada. In 1995, the Royal Commission on Aboriginal Peoples estimated that suicide rates across all age groups of Aboriginal people were on average three times higher than in the non-Aboriginal population. For registered Indians, the suicide rate was 3.3 times the national average; for Inuit, it was 3.9 times. Among Aboriginal youth aged 10 to 19 years, the suicide rate was five to six times higher than among their non-Aboriginal peers.[272]

Inuit regions had rates of suicide "which are 11 times the national average."

Data collection and analysis, knowledge translation and dissemination of accurate information are considered essential for early detection and effective intervention.

For young people, suicide prevention was seen as an area that needed urgent attention.

Witnesses told the Committee that the statistics do not provide the complete picture and that many incidents have gone unreported. According to Debbie Dedam-Montour, most suicide statistics do not account for suicides wrongly reported as accidental deaths, nor do they include incomplete suicides (suicide attempts). Witnesses stated that by 2005, the reported rates of suicide were much higher. Larry Gordon pointed out that Inuit regions had rates of suicide "which are 11 times the national average."[273] James Morris, speaking about the 32 isolated First Nations served by the Sioux Lookout First Nations Health Authority in northern Ontario, reported the extremely high incidence of suicide in the region:

> *The national rate for suicide for young people in Canada is 0 to 14.9 per 100,000. In some of our communities, the rate is 42.5 per 100,000. The suicide rate is 398 per 100,000 in the age group 15 years to 19 years. The national average is 12.9 per 100,000.*[274]

For all groups, surveillance, data collection and analysis, knowledge translation and dissemination of accurate information are considered essential for early detection and effective intervention. Onalee Randell explained:

> *The lack of Inuit-specific data makes it difficult for Inuit to work together across Canada. We have community-level data provided by regional boards on suicide incidence. There is no national reporting for Inuit suicide. It is*

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272 Royal Commission on Aboriginal Peoples. (1995) Choosing Life: Special Report on Suicide Among Aboriginal Peoples.

273 21 April 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/13evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

274 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

> *anecdotal from the communities. We do not have the same level of data on incidence of attempts or incidence of mental illness*[275]

For young people, suicide prevention was seen as an area that needed urgent attention. Jason Whitford reported that:

> *...of the close to 300 people we have met with and talked to about suicide prevention, probably 95 per cent had had suicide directly impact their family or a close friend.*
>
> *When working with the mainstream, it was the reverse. It was probably 10 per cent who had a family member or a close friend die by suicide.*[276]

The majority of witnesses talked about suicide as the end product of a series of very fundamental problems, all of them incorporated within the broad compass of the determinants of health.

Many factors contribute to suicide. A 1995 report by the Royal Commission on Aboriginal Peoples identified situational, socio-economic and culture stress as the major risk factors for suicide among Aboriginal peoples. Mental illnesses related to psycho-biological factors such as anxiety disorders or schizophrenia were documented infrequently.[277] This was reiterated by Arnold Devlin:

> *If you look at suicide in First Nation communities, I am not sure that you can use the mental illness model. I think that depression and substance abuse contribute, but there are other factors that are integral to that desperation, that despair, and that loss of hope that actively contribute to suicide.*
>
> *The 10 year-old or 14 year-old who commits suicide is not suffering from a mental illness. They have given up. If we look at it from a mental illness model, we miss that sense of historical dynamics.* [278]

The majority of witnesses talked about suicide as the end product of a series of very fundamental problems, all of them incorporated within the broad compass of the determinants of health. They argued that resources should be devoted at an earlier stage toward stopping or easing the problems contributing to the high rates of suicide in Aboriginal communities. Ron Evans, Chief of Norway House Cree Nation, insisted:

> *We do not wish to recite the devastation visited upon our peoples. We do wish that you understand that our peoples continue to suffer from what our Elders and healers say is unresolved grief over the generations. Some refer to this situation or condition as historic trauma or collective grief, and it manifests*

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[275] 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

[276] 31 May 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/16evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

[277] Royal Commission on Aboriginal Peoples. (1995) Choosing Life: Special Report on Suicide Among Aboriginal Peoples.

[278] 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

itself in the high proportion of our people addicted to alcohol, drugs, gambling or other forms of addiction and in high suicide rates, especially among our young people.[279]

James Morris, Executive Director, Nodin Counselling Services, in reference to some root causes of suicide, observed:

Some of the causes are oppression and colonization, going back 100 years. The problem cannot be understood by anybody who has not been colonized or oppressed. We understand because we have experienced it.

Part of the problem is the residential school system. Once again, if you have never been a residential school victim, you do not know how it is because you do not know how it feels. It is the same with racism. Racism is everywhere. Once again, if you have never been a victim of racism, you do not know what it is. If you are not affected by it, if you are not hurt by it, you do not respond to it. When you see somebody victimized by racism, you do not do anything because it does not bother you. We experience racism every day, everywhere. It is a fact of life.[280]

People talked about the need to integrate physical and mental health programs and services to reduce the tendency to define issues in silos and to "stove-pipe" services. Sheila Levy emphasized that suicide cannot be separated from other issues:

People talked about the need to integrate physical and mental health programs and services to reduce the tendency to define issues in silos and to "stove-pipe" services.

There is a tendency to view suicide, violence, addictions, abuse and mental health as separate issues. These problems receive separate funding while we should address the underlying commonalities in these issues.[281]

Onalee Randell supported greater integration of programs at the community level for more positive outcomes:

Individuals sent out for addictions treatment are returned to the communities without health or social services being notified of their return or any follow-up of the outcomes of their treatment. Children and youth who have had suicide attempts and are sent out of their communities for medical attention are returned to the communities with no follow up and, in some cases, no notification of health centre nurses who sent them out.[282]

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279 31 May 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/16evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

280 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

281 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

282 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

The Committee is extremely concerned about the high rates of suicide among Aboriginal peoples. It is more than a decade since the Royal Commission on Aboriginal Peoples highlighted this and the resultant devastation for Aboriginal communities in its special report. Instead of improvement, the Committee heard about deterioration.

The Committee observes that, starting in 2005, Health Canada is to allocate $65 million over five years to a new National Aboriginal Youth Suicide Prevention Strategy; the money flows at a rate of $15 million per year from year two to year five. It includes funding for First Nations on reserve and Inuit to support communities at risk, through crisis response and stabilization. Some additional funding for research will look at off-reserve Aboriginal youth.

The Committee is extremely concerned about the high rates of suicide among Aboriginal peoples.

The Committee wants concrete action to address the appalling suicide rate among Aboriginal children and adolescents.

The Committee sees a role for the proposed Canadian Mental Health Commission in helping to develop consistent standards and protocols, in understanding risk factors and in organizing a national suicide research agenda. But, most importantly, it wants concrete action to address the appalling suicide rate among Aboriginal children and adolescents. The Committee believes that this work would best be undertaken by the Canadian Mental Health Commission in close cooperation with other organizations such as the Canadian Institutes of Health Research and the Canadian Institute for Health Information.

In view of the clear need for immediate culturally appropriate actions, the Committee recommends:

99	**That the Canadian Mental Health Commission (see Chapter 16), as a high priority, identify measures to reduce the alarming suicide rates amongst Aboriginal peoples.** **That identification of these measures be a component of its priority action on an Aboriginal wellness and healing strategy.** **That the Government of Canada allocate a designated suicide fund that accommodates the distinct needs of each group of Aboriginal peoples.** **That the fund include specific allocations for implementing any measures identified by the Canadian Mental Health Commission as well as for increased research by the Canadian Institutes of Health Research and for specific data collection by the Canadian Institute for Health Information in collaboration with the National Aboriginal Health Organization.**

14.8.4 Reduction of Alcohol and Substance Addiction

As with suicide, witnesses talked about the interrelationship between alcohol and/or substance abuse and other social problems. James Morris reiterated that "All these social problems, suicide, sexual abuse, family violence, alcohol and drug abuse, are manifestations of deeper problems."[283] Debbie Dedam-Montour argued that "the broad term of 'family violence,' which is sexual, physical, emotional and psychological abuse, and neglect…has had a domino effect because it leads sufferers to self-medicate with alcohol or any other harmful substances and to involvement with correctional institutions."[284]

The Assembly of First Nations supported the need for appropriate funding to develop and administer regional treatment facilities for those who abuse solvents and those with drug addictions.

The Assembly of First Nations supported the need for appropriate funding to develop and administer regional treatment facilities for those who abuse solvents and those with drug addictions. Valerie Gideon told the Committee about proposals:

Inuit communities have a need for specific alcohol and addictions programs that are culturally based and use both harm reduction and abstinence models.

> *…to look at developing or creating new treatment centres that would have a broad mandate beyond strictly alcohol, for example, or some of the more well-known drugs to look at some of the emerging addictions, such as crystal meth, for example, that play a pivotal role in mental health and suicides in our communities.* [285]

Donna Lyon noted the lack of sufficient funding by Health Canada for addiction services:

> *There are long waiting lists to attend counselling and insufficient funding for patient transportation. Much of the funding is prioritized toward acute care operations and short-term crisis intervention.* [286]

Inuit communities have a need for specific alcohol and addictions programs that are culturally based and use both harm reduction and abstinence models:

> *There needs to be an increased number of Inuit addiction counsellors and early interventions. We need to have after-care and follow-up services in communities. No longer are people happy with going to six-week treatment centres and then*

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283 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

284 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

285 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

286 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

coming home to the same situations; the same overcrowding, the same high costs and no supports. —Onalee Randell[287]

The connected nature of alcohol and other substance abuse and suicide, along with other social problems, requires a coordinated population health approach.

The Committee supports the message that the connected nature of alcohol and other substance abuse and suicide, along with other social problems, requires a coordinated population health approach. Careful evaluation of what works best to achieve positive outcomes is essential. It is extremely important, therefore, that the proposed Canadian Mental Health Commission work very closely with other organizations such as the Canadian Institutes of Health Research and the Canadian Centre for Substance Abuse.

The Committee recommends:

100	**That the Canadian Mental Health Commission (see Chapter 16) identify measures to reduce the alarming alcohol and substance addiction rates amongst Aboriginal peoples.** **That identification of these measures be a component of its priority action on an Aboriginal wellness and healing strategy.** **That the Government of Canada allocate a designated fund for addiction that accommodates the distinct needs of each group of Aboriginal peoples.** **That the fund include specific allocations for implementing any measures identified by the Canadian Mental Health Commission as well as for increased research by the Canadian Institutes of Health Research and for specific data collection by the Canadian Centre for Substance Abuse in collaboration with the National Aboriginal Health Organization.**

14.9 ASSESSING DATA AND DOLLARS

Two things are important to the success of any strategy — money and data on what is happening. Money alone will not fix the poor health status of Aboriginal peoples, although there is no doubt that more must be spent. It is critical to have comprehensive data on where and on what money is currently being spent and what outcomes are the result. New approaches to the collection of information and evidence are needed both to improve care and to inform new approaches about how best to distribute the money to achieve the greatest results.

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[287] 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

14.9.1 Expanded Data

There is no ongoing data collection on the prevalence of mental illness and addictions among Aboriginal people.

The foundation of any effective strategy or action plan is data. Over the last decade, many reports — from those emanating from the Royal Commission on Aboriginal Peoples to those issued following the recent First Ministers' meeting with Aboriginal leaders — have called for development of a framework to collect and report comparable information across all Aboriginal groups.

The most definitive source of data about persons with disabilities in Canada (Participation and Activity Limitation Survey, PALS) provides no information specific to Aboriginal peoples.

Although the Government of Canada, as part of the Canada-Aboriginal Peoples Roundtable process in 2004, committed itself to the development of an Aboriginal report card, there is no ongoing data collection on the prevalence of mental illness and addictions among Aboriginal people. Witnesses acknowledged that federal departments have difficulty in getting comprehensive data relating to mental health on all Aboriginal populations. For First Nations and Inuit, Indian and Northern Affairs Canada, Health Canada and Correctional Service Canada all offer specific programs and services, but the data analyses relating to them are limited.

At Social Development Canada, the most definitive source of data about persons with disabilities in Canada (Participation and Activity Limitation Survey, PALS) provides no information specific to Aboriginal peoples. Although suggesting that rates of disability — including mental disabilities — may be much higher among Aboriginal persons than in the rest of the population, Cecilia Muir, Director General, Office of Disability Issues, explained:

> *In terms of data, we do not have specific data. I have talked about the population size, but it is not specific to Aboriginal persons. They were not over-sampled, so we do not have greater detail about the [incidence] in the Aboriginal population.*[288]

Witnesses called for baseline data from which specific targets could be established.

Witnesses stressed the need for better data to support informed decisions that would contribute to wellness. They called for baseline data from which specific targets could be established. They urged greater accountability and transparency by governments, providers and others so that progress toward established goals could be tracked and measured over time. Elsie Bastien pointed out:

> *We need to develop baseline data of program and service delivery usage by Aboriginal populations. It is important that mechanisms be developed to systemically collect and analyze longitudinal Aboriginal health information. A*

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[288] 21 April 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/13evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

centralized focussed approach will be helpful to coordinate, foster comparability, and create linkages among Aboriginal health and data sources.[289]

Witnesses emphasized the need for data specific to each group.

Witnesses emphasized the need for data specific to each group. The First Nations regional longitudinal national health survey was held out as a potential vehicle for ongoing collection of mental health data and monitoring of the equality of access to mental health services in First Nations communities. Housed within the First Nations Centre at the National Aboriginal Health Organization, the regional health survey is community-based, the only survey that goes on reserve and collects data directly from First Nations people.

There is a limited amount of Inuit- and Métis-specific data on mental health, as in other areas of health. It is very difficult to measure progress when data are absent or not available in sufficient detail.

> *For Inuit in particular, our information is missing or mixed in with the data that includes other Aboriginal peoples. Without the correct Inuit health stats, development and evaluation of programs and services will not be based on reliable evidence. —Larry Gordon*[290]

> *Across the board, while we are gathering data and accumulating an evidence base for First Nations and Inuit, Metis lag far behind in gaining initial basic baseline data. —Bernice Downey*[291]

The Committee believes that, without a clear, complete and accurate picture of the current situation facing Indian, Inuit and Métis populations, it will be extremely difficult to set standards and targets and provide the required resources for programs and services that will be effective in improving the overall wellness of Aboriginal peoples.

One witness stressed the need for careful analysis of data, taking into account factors such as culture. Elsie Bastien noted that an evaluation of service delivery can measure outcomes as poor based on an imperfect theory:

> *An error or poor outcome is an indicator of incomplete data or an inadequate hypothesis that did not result in a successful completion of a certain purpose and/or intent. It is imperative that culturally appropriate program indicators are included within the proposed environmental scan.*

> *[...] An accurate picture would be data not generated from a Western medical model, which is our current practice, but generated from an Aboriginal world view on health and wellness.*[292]

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289 9 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/21evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

290 21 April 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/13evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

291 21 April 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/13evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

292 9 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/21evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

The Committee believes that, without a clear, complete and accurate picture of the current situation facing Indian, Inuit and Métis populations, it will be extremely difficult to set standards and targets and provide the required resources for programs and services that will be effective in improving the overall wellness of Aboriginal peoples. In particular, the Committee recognizes the importance of developing data that will provide the baseline against which new investments can be tracked over time and the outcomes of new programs and services measured.

The Committee does not understand how federal departments, knowing the abysmal health status of Aboriginal peoples and the fact that this population is universally considered to be at risk, could have failed to collect, or to support others in collecting, the data required to develop a strategy to address the problem in a meaningful way and to measure progress subsequently with respect to outcomes.

The Committee does not understand how federal departments, knowing the abysmal health status of Aboriginal peoples and the fact that this population is universally considered to be at risk, could have failed to collect, or to support others in collecting, the data required to develop a strategy to address the problem in a meaningful way and to measure progress subsequently with respect to outcomes.

The Committee recommends:

101 **That the Government of Canada work with the National Aboriginal Health Organization to assess the appropriateness of the First Nations regional health survey for use as a model for data collection for other Aboriginal peoples.**

That the Canadian Institute for Health Information be encouraged to provide analysis of health determinants data related to each of the Aboriginal peoples.

That the Canadian Mental Health Commission (see chapter 16) work with the Canadian Institute for Health Information to improve understanding of mental health causes and outcomes.

14.9.2 Transformed Funding

Witnesses stressed repeatedly that the key to capacity is adequate, flexible and ongoing funding. In particular, multi-year sustainable funding is essential to counter the past experience of communities that devoted resources to set up a program only to discover that the available funding would support it for only a year or two. Onalee Randell emphasized that:

Multi-year sustainable funding is essential to counter the past experience of communities that devoted resources to set up a program only to discover that the available funding would support it for only a year or two.

> *The short-term unstable and uncertain funding causes incredible barriers to the delivery of mental wellness programs. […]Multi-year flexible funding is*

required. It is difficult for small communities to develop programs and not know if those programs will be funded the next year.[293]

Valerie Gideon urged that funding and reporting structures be transformed:

...so that they are enabling tools rather than barriers to the implementation by communities of holistic approaches to mental wellness. An example of that transformation is multi-year flexible funding arrangements and reporting based on outcomes versus administrative data.[294]

Irene Linklater noted that integrated models of funding between federal agencies are being introduced that allow for the support of comprehensive programs with long-term sustained funding and rigorous accountability requirements:

...there is a new contribution model between First Nations and Inuit Health Branch and Indian and Northern Affairs Canada that looks at block funding, multi-year arrangements. We are encouraged by that process.[295]

Needs-based funding formulas that would provide stable, predictable funding to facilitate financial planning are necessary.

The First Nations reporting requirements established by the federal government were criticized by the Auditor General of Canada as being onerous; she commented that they "are a significant burden, especially for communities with fewer than 500 residents. We estimated that at least 168 reports are required annually by the four federal organizations that provided the most funding for major federal programs."[296]

Needs-based funding formulas that would provide stable, predictable funding to facilitate financial planning are necessary. Valerie Gideon supported the movement to more targeted and consolidated funding for First Nations health, a focus on block funding and the development of a "system of healing centres and lodges under First Nations control to bridge jurisdictions and individual ministries, and to pool both health and social resources from all sources." She maintained that this funding would be most effective with:

...an increased transfer of funding to First Nations communities to develop and maintain their own health centre facilities and, underneath that, the mental health services with strategic linkages to provincial and territorial jurisdictions.[297]

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293 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

294 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

295 1 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/16evc-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

296 Auditor General of Canada. (December 2002) Streamlining First Nations Reporting to Federal Organizations. http://www.oag-bvg.gc.ca/domino/reports.nsf/html/20021201ce.html.

297 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

The overall allocation of money for mental health purposes was challenged by several witnesses. Donna Lyon called into question the current funding focus on "affordability and not need," when the need is so great for mental health services.[298]

According to Ron Evans, funding can be a source of wellness. He linked research from Harvard University on socio-economic development and from British Columbia on suicide prevention in First Nations to demonstrate the interconnected nature of economic and cultural stability in communities:

> *The Harvard project on Native American tribes found, through several years of onsite work with First Nations in U.S. and Canada, that business success in First Nations in Canada and tribes in the United States depend upon a few factors such as a stable government and regulations, adequate funding, and, importantly, the cultural match of the business to the community. Similarly, the ongoing 14-year study of Chandler and Lalonde, "Cultural Continuity as a Hedge Against Suicide," found that First Nations who had control of essentially government functions such as education, health, community services, who worked to resolve land claims and who actively practised their cultural traditions, had little to no suicide.*[299]

14.9.3 Funding for Youth

Irene Linklater was one of several witnesses to talk about the lack of youth-specific funding and the problems created when program funding is delayed. Referring to the importance of youth councils that represent young people in communities, she stated:

> *One of the problems that they have is access to funding. There is really no specific funding for youth engagement at the community level for, say, the youth suicide strategies.*
>
> *In Manitoba here, we have funding for youth through the Assembly of Manitoba Chiefs, but every year we fight for funding. We sometimes do not get our funding until October.*[300]

While Jason Whitford, Coordinator, Youth Council, Assembly of Manitoba, acknowledged that it does not always take a lot of money to do positive things in a community, any discontinuity in funding makes it more difficult to operate. Even the Keewatin Winnipeg Youth Initiative, recognized as best practice and funded by the Urban Multipurpose Youth Centres Initiative out of Heritage Canada, experiences funding problems:

> *We are waiting for funding once again for the year. We will probably end up losing about five months out of the year. However, based on past experience,*

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298 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

299 31 May 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/16evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

300 1 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/16evc-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

> *we are going to just continue to deliver programs and services for urban Aboriginal youth and convince the management of AMC to support us in operating that project.*[301]

For the Inuit as well, although the presence of and participation by youth is seen as crucial to community wellness, particularly to suicide prevention, the funding is erratic. Larry Gordon recounted how the National Inuit Youth Council has been active in role modelling and in suicide prevention:

> *The funding provided to Inuit youth for these important initiatives is provided year to year with no guarantees, despite the success the work had in outreach to Inuit youth who are the most at-risk population for suicide in all of Canada.*[302]

As part of the September 2004 federal, provincial and territorial Health Agreement, the federal government announced new funding of $65 million allocated over five years for an Aboriginal youth suicide prevention strategy. Ian Potter indicated that discussions about its distribution were ongoing:

> *We are working on the program jointly with the Assembly of First Nations, the Inuit Tapiriit Kanatami and with input from other national Aboriginal organizations, provinces and territories and federal departments. This strategy will support communities in stopping youth from becoming suicidal, reaching youth who are at risk of committing suicide and preventing suicide clusters in the aftermath of a completed suicide.*[303]

For Arnold Devlin, funding for a serious problem like suicide that ends after a five-year period is a major concern:

> *One of our greatest concerns is the sustainability of the program; it needs to be linked with some long-term planning and this will be the key to success. If we just think this will be our solution, it will not be effective.*[304]

14.9.4 Recommendation for Action

The Committee believes it self-evident that long-term suffering will require long-term funding. Aboriginal peoples have endured a lengthy period of alternating indifference and piecemeal attention from the federal and other governments entrusted with their well-being. The Committee is aware of the November 2005 commitments for an Aboriginal Blueprint on health. However, it recognizes that previous announcements such as the $200 million for

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301 31 May 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/16evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

302 21 April 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/13evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

303 20 April 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/13eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

304 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

an Aboriginal Health Transition Fund in September 2004 did little to alleviate the health needs of Aboriginal peoples. Discussions relating to the distribution of that money remained "ongoing" some 14 months later. In the meantime, the problems are not getting any better and are probably worsening. There are no data to inform us.

The Committee heard the urgent calls for multi-year, sustained funding appropriate to the magnitude of the problems facing Aboriginal peoples. It has already recommended that the proposed Canadian Mental Health Commission, in consultation with its Aboriginal advisory committee, establish timelines and funding levels to implement wellness and healing programs. It urges prompt movement on this overall strategy and action plan.

The Committee has already recommended the creation of an interdepartmental committee to report to Parliament every two years with a clear inventory of ongoing federal programs and services and the money spent on them. It has also recommended that the federal government work with Aboriginal peoples to identify necessary programs and services combined with appropriate oversight and evaluation criteria.

The Committee further recommends:

102	**That the Government of Canada undertake immediate analyses of the current level of federal funding for Aboriginal peoples.** **That the analyses assess how much funding would be required to change key health determinants for Aboriginal peoples.** **That the analyses include a short, medium and long range assessment for funding needs.** **That the first report to Parliament by the inter-departmental committee recommended in section 14.6.3 include the results of the analyses.**

14.10 CONCLUSION

In a country proud of the rich personal opportunities available to most citizens and the wealth of its human and natural resources, the situation facing Aboriginal people on a daily basis is a shameful blot on the public record. Still, there is reason to hope. The Committee heard that Aboriginal peoples face high levels of mental distress but experience a low incidence of mental disorder. This suggests strongly that many of the current negative outcomes, whether suicide or addiction associated with despair, can be reversed. There is great human potential among Aboriginal peoples, especially given the youthfulness of the population.

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There is great human potential among Aboriginal peoples, especially given the youthfulness of the population.

The Committee was encouraged by the repeated testimony that the mental distress facing Aboriginal peoples is preventable and that the effects of decades of fragmented and often negative treatment could be alleviated. It agrees that efforts on the part of governments, communities and individuals can produce positive effects on wellness, especially wellness derived from mental health.

The Committee believes that Canada's long tradition with population health initiatives offers significant promise for improvement in the mental and physical health status of Aboriginal peoples, primarily through practical changes to their social and physical environments. Actions in education, housing, employment and community support can produce significant long-term benefits to Aboriginal peoples.

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The Committee is aware of many initiatives of Aboriginal communities across the country to change their social and physical environments. It also recognizes the ongoing collaborative efforts among all groups — First Nations, Métis, and Inuit. The Committee commends all participants for these shared endeavours.

The Committee strongly supports the development of a national strategy that is holistic, culturally appropriate, community-based, equitable for all Aboriginal peoples, and supported by sustained funding. It calls for the preparation of an action plan based on the determinants of health, one that incorporates specific goals and timelines to achieve measurable beneficial outcomes and that fosters collaboration among all those working to achieve these objectives.

The Committee supports increased, stable, multi-year funding agreements to provide long-term support for long-term goals for a population experiencing serious but preventable problems. It knows that all Canadians are looking for progress on key outcomes that will improve the overall well-being of Aboriginal peoples.

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ANNEXE A: RECOMMENDATIONS I

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PARTIE V

Leadership fédéral

> *[...] lancer[...] et coordonner[...] des activités dans l'ensemble des ministères fédéraux pour s'acquitter des responsabilités fédérales à l'égard de populations précises relevant de sa compétence immédiate. — Le Dr Albert Schumacher, président, Association médicale canadienne*[1]

Le gouvernement fédéral est responsable des programmes et services de santé mentale offerts à sept groupes de clients. Pour chacun de ces groupes, le présent chapitre donne une description détaillée des pouvoirs du fédéral et de l'éventail de programmes et services fédéraux en place dans les secteurs de la santé mentale, de la maladie mentale et de la toxicomanie. On trouvera également dans ce chapitre une évaluation des besoins de chaque groupe, et un commentaire sur la situation de chacun.

À la connaissance du Comité, c'est la première fois qu'est entreprise une telle évaluation des besoins de santé mentale des groupes de clients qui relèvent de la compétence fédérale. Par conséquent, après avoir examiné la situation de chaque groupe, le Comité examinera le fait même que le gouvernement fédéral soit responsable des besoins de santé mentale du plus d'un million de Canadiens qui relèvent de sa compétence. En conclusion de ce chapitre, le Comité propose quelques éléments d'une approche intégrée visant à améliorer les résultats des interventions de santé mentale menées auprès des divers groupes qui forment la clientèle fédérale.

Pour faciliter la lecture de ce long chapitre, le tableau suivant donne un bref aperçu du contenu de chaque section, chacune portant sur un groupe de clients. Chaque groupe y est identifié, de même que le ministère fédéral dont il relève, ainsi que les activités de santé qui lui sont offertes.

Tableau 1 : Aperçu des groupes de clients qui relèvent du fédéral

Groupe de clients	Ministère fédéral	Activités de santé mentale
Premières nations et Inuits (13.1)	Santé Canada	Soins de santé communautaires aux Premières nations qui vivent dans des réserves; Médicaments non assurés et interventions d'urgence en situation de crise aux membres inscrits des Premières nations et aux Inuits reconnus; Centres de traitement de la toxicomanie.
	Affaires indiennes et du Nord Canada	Services de base aux Premières nations des réserves et aux communautés inuites : éducation, soutien du revenu, logement, prévention de la violence familiale.

[1] 20 avril 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/13eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

Groupe de clients	Ministère fédéral	Activités de santé mentale
Délinquants sous responsabilité fédérale (13.2)	Service correctionnel Canada	Services de base : évaluation infirmière à l'accueil; admission au centre de traitement si nécessaire et si possible; services généraux en établissement hospitalier; Services essentiels lorsqu'en centre correctionnel communautaire; services de santé non assurés si approuvés.
Forces armées canadiennes (13.3)	Défense nationale	Services de santé mentale non urgents en clinique externe à la clinique de la base, au centre de santé ou en groupes de soutien; Soins spécialisés payés à la province; aiguillage vers centres de soutien en cas de stress post-traumatique.
Anciens combattants (13.4)	Anciens Combattants Canada	Services de soins de santé communautaires au-delà des limites des régimes provinciaux ou territoriaux; Soins institutionnels à Sainte-Anne-de- Bellevue (Québec) et autres hôpitaux liés par contrat dans les provinces; Services conjoints avec MDN en cas de stress post-traumatique.
GRC (13.5)	GRC	Services généraux offerts au sein de la division régionale pour garantir la capacité physique et mentale nécessaire à l'exercice des fonctions; Recours aux services provinciaux sur autorisation.
Immigrants et réfugiés (13.6)	Citoyenneté et Immigration Canada	Services de santé mentale essentiels et d'urgence (médecin, hôpital, médicaments) pour ceux qui ne peuvent payer.
Employés de la fonction publique (13.7)	Conseil du Trésor	Services et autres avantages non couverts par les régimes provinciaux/territoriaux; Services de consultation et soutien des employés.

D'entrée de jeu, le Comité affirme qu'il s'attend du gouvernement fédéral de même que des gouvernements provinciaux et territoriaux qu'ils garantissent aux clients qui relèvent d'eux l'accès aux transformations du système déjà indiquées au chapitre 5. Autrement dit, le Comité compte bien que les Premières nations et les Inuits, les délinquants sous responsabilité fédérale, les membres des Forces canadiennes, les anciens combattants, les membres de la GRC, les immigrants et réfugiés et les employés de la fonction publique soient inscrits d'emblée dans un système de santé mentale axé sur la guérison, centré sur la personne, implanté en milieu communautaire, et pleinement intégré tant du point de vue de l'éventail de soins que des groupes d'âge.

Le Comité se réjouit de constater que plusieurs ministères et organismes fédéraux sont déjà orientés en ce sens. Certains ministères offrent des services de prise en charge et font appel à un plus grand éventail de fournisseurs de services provinciaux de santé mentale. D'autres misent sur l'amélioration des facteurs déterminants de la santé mentale comme le logement, l'emploi et l'ensemble des besoins sociaux. Quelques ministères et organismes travaillent en collaboration les uns avec les autres, et avec leurs homologues des provinces et territoires, dans le cadre d'initiatives de santé mentale.

13.1 LES PREMIÈRES NATIONS ET LES INUITS

Les Inuits sont heureux de l'engagement pris par le fédéral envers un renouvellement de la relation. Nous estimons important un engagement plus marqué en faveur d'une stratégie de défense de la santé mentale propre aux Inuits. —Larry Gordon, président, Comité national sur la santé des Inuits, Direction de la santé, Inuit Tapiriit Kanatami[2]

Un plan d'action conjoint et une stratégie du bien-être entre le gouvernement fédéral et les Premières nations résoudraient immédiatement la crise de la santé mentale d'une façon collaborative, globale et pertinente sur le plan culturel. —Valerie Gideon, directrice du Secrétariat à la santé et au développement social, Assemblée des Premières nations[3]

13.1.1 La compétence fédérale

C'est à Santé Canada qu'incombe la responsabilité principale des services de santé, y compris les services de santé mentale, offerts aux Premières nations et aux Inuits qui vivent dans des réserves et dans de nombreuses communautés éloignées; ces services sont offerts par le biais de dispensaires et de centres de santé.

Dans l'*Acte de l'Amérique du Nord britannique, 1867*, le paragraphe 91(24) confie la responsabilité législative « des Indiens et des terres réservées aux Indiens » à la compétence exclusive du Parlement fédéral. Le Parlement, à son tour, a promulgué la *Loi sur les Indiens* qui établit les critères qui définissent un « Indien inscrit » ainsi que le cadre juridique des responsabilités fédérales. Une décision de la Cour suprême, rendue en 1939, a déterminé que les Inuits (qu'on appelait alors Eskimos) étaient des Indiens aux fins du paragraphe 91(24)[4].

Il importe de signaler que nous nous intéressons dans ces pages uniquement aux Premières nations et aux Inuits qui relèvent directement du fédéral. Le gouvernement fédéral n'est pas responsable de tous les peuples autochtones; on estime qu'un tiers environ de la population autochtone n'a pas accès aux programmes et services fédéraux. À l'heure actuelle, le gouvernement fédéral offre aux Indiens inscrits (aussi appelés Premières nations) des programmes et services qui ne sont pas accessibles aux Indiens non inscrits ni aux Métis. Par ailleurs, une partie, mais non la totalité, des programmes et services fédéraux sont offerts aux Inuits.

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2 21 avril 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/13evb-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

3 20 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/27eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

4 Loi sur les Indiens, L.R.C. 1985, ch. I-5, http://lois.justice.gc.ca/fr/I-5/, Tonina Simeone, Sphères de compétence fédérale et provinciale et peuples autochtones, TIPS-88F, Bibliothèque du Parlement, 2001. Mary Hurley, La Loi sur les Indiens, TIPS-17, Bibliothèque du Parlement, 2004, http://lpintrabp.parl.gc.ca/apps/tips/printable/tip17-f.pdf

Ce chapitre ne porte que sur les Premières nations et les Inuits considérés admissibles aux programmes et services fédéraux de santé mentale, dont la plus grande partie relève des ministères de Santé Canada et d'Affaires indiennes et du Nord. Le prochain chapitre (chapitre 14) aura une portée plus vaste puisqu'il prendra en compte les besoins de santé mentale de tous les peuples autochtones, y compris les Indiens non inscrits (et ceux qui vivent hors des réserves) de même que les Métis. Le chapitre 14 présentera aussi les grandes lignes d'une stratégie globale, intégrée et communautaire, de santé et de régénération adressée à tous les groupes autochtones et faisant appel à des approches multiples.

C'est à Affaires indiennes et du Nord Canada qu'incombe la responsabilité première des obligations constitutionnelles et législatives à l'endroit des Indiens et des Inuits. En administrant la *Loi sur les Indiens,* le ministère soutient les efforts d'autodétermination, ainsi que le développement économique, éducationnel, culturel, social et communautaire des Indiens inscrits et de certains Inuits. Selon le Rapport sur le rendement du ministère au 31 mars 2005, le nombre des Indiens inscrits s'élevait alors à 733 626[5]. Le rapport ne fait état d'aucun chiffre sur la population inuite.

La division des responsabilités entre le ministère de la Santé fédéral et ses homologues provinciaux ou territoriaux « porte souvent à confusion, même pour nous qui travaillons dans ce domaine à tous les jours ».

C'est à Santé Canada qu'incombe la responsabilité principale des services de santé, y compris les services de santé mentale, offerts aux Premières nations et aux Inuits qui vivent dans des réserves et dans de nombreuses communautés éloignées; ces services sont offerts par le biais de dispensaires et de centres de santé. Le Rapport sur le rendement de 2005 indique en outre que Santé Canada offre des « services de santé supplémentaires à environ 765 000 membres admissibles des Premières nations et des Inuits »[6].

Ian Potter, sous-ministre adjoint, Direction générale de la santé des Premières nations et des Inuits, Santé Canada, décrit la Politique de 1979 sur la santé des Indiens, laquelle définit le rôle actuel du gouvernement fédéral et des gouvernements provinciaux[7] :

> *Ainsi, le gouvernement fédéral demeurait responsable du financement et des services dans les réserves éloignées et dans les endroits où les provinces n'offrent aucun service. Cela signifiait que le gouvernement fédéral serait responsable des services de santé publics dispensés dans les réserves, y compris les services de prévention. Cela signifiait aussi que le gouvernement fédéral serait responsable des coûts associés aux médicaments non assurés, aux soins dentaires et au transport nécessaire*

5 Affaires indiennes et du Nord Canada, Rapport sur le rendement pour la période se terminant le 31 mars 2005, p. 21, http://www.tbs-sct.gc.ca/rma/dpr1/04-05/INAC-AINC/INAC-AINCd45_f.pdf.

6 Santé Canada, Rapport sur le rendement pour la période se terminant le 31 mars 2005, p. 6, http://www.tbs-sct.gc.ca/rma/dpr1/04-05/HLTH-SANT/HLTH-SANTd45_f.pdf.

7 Santé Canada, Politique sur la santé des Indiens 1979, http://www.hc-sc.gc.ca/fnih-spni/services/indi_health-sante_poli_f.html.

des membres des Premières nations et aux Inuits vivant dans les réserves [et hors réserve [8].

M. Potter reconnaît que la division des responsabilités entre le ministère fédéral de la Santé et ses homologues provinciaux ou territoriaux « porte souvent à confusion, même pour nous qui travaillons dans ce domaine à tous les jours ». Il nous a néanmoins donné la brève description suivante :

> *Les services de base en santé mentale et lutte contre la toxicomanie sont assurés principalement par les provinces à tous leurs résidents, y compris les membres des Premières nations, les Inuits et les autres peuples autochtones. Ces services englobent les soins hospitaliers universels, les soins psychiatriques et les soins médicaux. Les provinces offrent également des services communautaires de prévention, des services de traitement ambulatoire et de suivi, des services de désintoxication et des services de traitement de la toxicomanie en résidence*[9].

13.1.2 Programmes et services fédéraux

Affaires indiennes et du Nord Canada et Santé Canada délèguent de plus en plus de pouvoirs aux Premières nations et à certaines communautés inuites dans l'administration et la mise en œuvre de nombreux programmes et services essentiels à la santé mentale. Des critères d'admissibilité précis continuent de s'appliquer à ces programmes, quel que soit le fournisseur :

Dans le champ de compétence fédéral, Affaires indiennes et du Nord Canada est le ministère qui offre le plus grand nombre de programmes et de services liés aux grands facteurs déterminants de la santé mentale. Il offre aux Premières nations des réserves des services similaires à ceux qui sont offerts par les provinces à la population générale

- Les Indiens doivent être inscrits en vertu de la *Loi sur les Indiens* et doivent figurer au Registre des Indiens; les Inuits ont un numéro de bénéficiaire.

- Pour certains services, l'approbation des autorités ministérielles est requise.

- Les programmes sont offerts aux personnes admissibles qui résident ou vivent ordinairement dans une réserve ou une communauté inuite reconnue.

Dans le champ de compétence fédéral, Affaires indiennes et du Nord Canada est le ministère qui offre le plus grand nombre de programmes et de services liés aux grands facteurs déterminants de la santé mentale. Il offre aux Premières nations des réserves des services similaires à ceux qui sont offerts par les provinces à la population générale, soit des services d'éducation, de soutien du revenu et de soutien aux infrastructures. Ces services représentent environ 80 p. cent du financement total accordé aux réserves.

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8 20 avril 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/13eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

9 20 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/13eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

Le Programme d'éducation élémentaire et secondaire d'Affaires indiennes et du Nord Canada assure l'accès à l'école soit en finançant des services d'enseignement dans les réserves ou en couvrant les coûts de fréquentation des écoles provinciales ou territoriales. Son programme d'aide sociale permet aux individus et aux familles qui vivent dans les réserves de satisfaire les besoins fondamentaux que sont la nourriture, le vêtement et le logement. Son programme de prévention de la violence familiale finance des refuges dans les réserves, rembourse les refuges hors réserve qui offrent des services aux Premières nations résidant habituellement dans les réserves, et subventionne des programmes communautaires de prévention de la violence familiale.

La Direction générale de la santé des Premières nations et des Inuits de Santé Canada estime à 267,5 millions de dollars ses dépenses annuelles en programmes et services liés à la santé mentale, à la maladie mentale et à la toxicomanie.

La Direction générale de la santé des Premières nations et des Inuits de Santé Canada estime à 267,5 millions de dollars ses dépenses annuelles en programmes et services liés à la santé mentale, à la maladie mentale et à la toxicomanie. Cela comprend les 36,4 millions de dollars consacrés en 2004-2005 à des médicaments pour le traitement de la maladie mentale et de la toxicomanie dans le cadre du Programme des services de santé non assurés[10].

Cette estimation comprend aussi les programmes communautaires de prévention et de promotion mis sur pied dans les réserves et les communautés inuites.

> *[...] 40 millions de dollars au financement sur une base continue aux programmes communautaires de santé mentale dans le cadre de l'initiative Pour des collectivités en bonne santé et un autre 51 millions annuellement à des activités axées sur la santé mentale et le développement de l'enfant, dans le cadre de l'initiative Grandir ensemble.*

En outre, des programmes de lutte contre la toxicomanie sont offerts aux Premières nations et aux Inuits par l'entremise :

> *[...] du Programme national de lutte contre l'abus d'alcool et de drogues chez les Autochtones (59 millions par année), du Programme national de lutte contre l'abus des solvants chez les jeunes (11 millions par année), de la stratégie de lutte contre le tabagisme chez les Premières nations et les Inuits (12 millions par année) et de la stratégie canadienne antidrogue (1 million par année)*[11].

Les services de consultation, généralement offerts par des psychologues, sont couverts par le Programme des services de santé non assurés et sont accessibles aux Premières nations et aux Inuits quel que soit leur lieu de résidence. Kathryn Langlois, directrice générale, Direction des programmes communautaires, Direction générale de la santé des Premières

10 Lettre de Ian Potter, sous-ministre adjoint, Direction générale de la santé des Premières nations et des Inuits, Santé Canada au sénateur Michael Kirby, président du Comité sénatorial permanent des affaires sociales, des sciences et de la technologie, le Sénat, 7 septembre 2005.

11 20 avril 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/13eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47

nations et des Inuits, Santé Canada, précise que la responsabilité fédérale se limite aux interventions de courte durée :

> *Nous assurons les consultations d'urgence en santé mentale et ensuite, un aiguillage est fait au système provincial. L'accès est le même que pour les personnes qui ne vivent pas dans les réserves, par l'urgence ou le médecin de famille.[...] C'est la province [qui paie]*[12].

Kathryn Langlois a aussi parlé des travaux entrepris par le Ministère sur la question du suicide après qu'un groupe consultatif sur la prévention du suicide ait été créé en 2002 par Matthew Coon Come, alors chef national, et Alan Rock, alors ministre de la Santé. Le nouveau financement annoncé en septembre 2004 comprenait 65 millions de dollars sur cinq ans accordés à l'initiative de prévention du suicide chez les jeunes; 5 millions ont été accordés en 2005 et 15 millions pour chacune des quatre années suivantes.

Santé Canada a aussi créé un comité consultatif sur la santé mentale des Premières nations et des Inuits chargé d'élaborer un plan d'action stratégique pour l'amélioration de la santé mentale des populations visées.

Santé Canada a aussi créé un comité consultatif sur la santé mentale des Premières nations et des Inuits chargé d'élaborer un plan d'action stratégique pour l'amélioration de la santé mentale des populations visées. Le comité est formé de représentants de l'Assemblée des Premières nations, de la Inuit Tapiriit Kanatami, des réseaux fédéraux, provinciaux et territoriaux, d'organismes autochtones et non autochtones spécialisés en santé mentale et toxicomanie, d'Affaires indiennes et du Nord Canada, et de l'Agence de santé publique du Canada. Au terme d'une séance de planification stratégique tenue en novembre 2005, une première ébauche de plan a été soumise au comité en février 2006[13].

13.1.3 Évaluation des besoins du groupe client

Les Indiens inscrits et les Inuits reconnus qui composent la clientèle fédérale présentent un ensemble très divers de caractéristiques. Par exemple, bien que les programmes et services soient principalement offerts aux Premières nations qui vivent dans des réserves, les gens vont et viennent régulièrement. Certains Inuits vivent dans les territoires visés par les accords territoriaux, mais d'autres non.

Dans l'ensemble, ces clients ont un état de santé « beaucoup moins bon que celui du reste de la population canadienne ».

Dans l'ensemble, ces clients ont un état de santé « beaucoup moins bon que celui du reste de la population canadienne »[14]. Et la prestation de service est rendue plus difficile en raison de

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12 20 avril 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/13eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

13 Lettre de Ian Potter, sous-ministre adjoint, Direction générale de la santé des Premières nations et des Inuits, Santé Canada au sénateur Michael Kirby, président du Comité sénatorial permanent des affaires sociales, des sciences et de la technologie, le Sénat, 7 février 2006, p. 2.

14 Conseil canadien de la santé, *L'état de santé des Premières nations, des Métis et des Inuits du Canada*, janvier 2005, http://healthcouncilcanada.ca.c9.previewyoursite.com/docs/papers/2005/BkgrdHealthyCdnsENG.pdf.

la grande dispersion géographique de cette clientèle, dont une grande partie vit dans des communautés éloignées ou isolées.

13.1.3.1 Les programmes et services d'Affaires indiennes et du Nord Canada

Affaires indiennes et du Nord Canada est responsable d'un grand nombre de facteurs jugés essentiels à une approche globale de la santé mentale des Premières nations et des Inuits, notamment le développement économique, le logement et l'éducation. Certains témoins ont dit au Comité que les efforts du Ministère étaient bien inférieurs aux attentes. Irene Linklater, directrice de recherche, Unité de recherche et d'élaboration des politiques, Assemblée des chefs du Manitoba, critique le fait que :

> *[L]e ministère des Affaires indiennes a consacré 13 millions de dollars à l'aide sociale pour chaque dollar consacré au développement économique. En conséquence le tiers ou même la moitié des membres des Premières nations du Manitoba qui vivent sur une réserve vivent de prestations d'aide sociale, la proportion allant de 24 à 88 p. cent selon les collectivités*[15].

Certains témoins ont aussi établi un lien entre la précarité des conditions de logement et leur incidence négative sur la santé mentale :

> *Il y a aussi l'expérience de l'itinérance, ou ce qu'on appelle l'itinérance invisible, c'est-à-dire que les logements sont tellement surpeuplés qu'on passe constamment de l'un à l'autre, et cela ne se reflète pas dans les statistiques; autrement dit, il n'existe pas de cadre statistique qui reflète cette réalité. L'absence de logements adéquats est aussi associée — et les études le confirment — au manque d'hygiène, à la mauvaise santé et à une longévité réduite. —Irene Linklater*[16]

> *La création d'un programme fédéral de logements dans les régions inuites de l'Arctique remédierait à la pénurie de logements et atténuerait, en outre, certains problèmes sociaux comme la violence familiale et les dépendances. — Larry Gordon*[17]

Donna Lyon, de l'Organisation nationale de la santé autochtone, a parlé des limites du soutien à l'éducation postsecondaire et de la difficulté d'obtenir des fonds de source

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15 Selon Linklater, ces statistiques proviennent d'une recherche menée par l'Assemblée des chefs du Manitoba en 2001; 1er juin 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/16evc-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

16 1er juin 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/16evc-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

17 21 avril 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/13evb-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

ministérielle. Même quand les ressources sont disponibles, indique-t-elle, elles sont souvent insuffisantes au soutien d'un étudiant qui a une famille à charge.

> *[B]ien des gens n'ont pas accès aux fonds et, s'ils reçoivent de l'aide, ils obtiennent parfois une allocation de subsistance qui est souvent insuffisante. Ainsi des familles doivent vivre avec 1 100 $ par mois, peut-être*[18].

Larry Gordon signale l'absence d'infrastructures et d'emplois dans le Nord pour les Inuits instruits qui veulent revenir chez eux et contribuer à l'économie de leurs communautés :

> *Bien souvent, lorsque les gens partent du Nord pour y revenir ensuite, ils n'y trouvent pas de travail. Ils ont suivi des cours, ils ont un diplôme, mais il n'y a pas de travail pour eux. Ils deviennent ingénieurs. Le seul travail qu'ils peuvent trouver, c'est dans le Sud, à cause de leur formation et de leurs antécédents*[19].

13.1.3.2 Les programmes et services de Santé Canada

Malgré les progrès constatés depuis un an, les témoins critiquent les accords de financement de Santé Canada qu'ils trouvent compliqués, de trop courte durée, et insuffisants par rapport aux besoins de santé mentale de la population. Ils souhaitent une plus grande intégration entre ministères fédéraux afin de soutenir des programmes de nature plus globale et de durée plus longue.

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Irene Linklater dit que pour les Premières nations, les transferts de fonds destinés aux programmes de santé mentale mis en œuvre dans les réserves sont rigides, déroutants et insuffisants :

Le financement instable, incertain et de trop courte durée nuit à la mise en œuvre des programmes de santé mentale

> *Parfois le gouvernement fédéral envoie de l'argent à la province, alloue un certain montant par membre des Premières nations en fonction de la population des Premières nations dans la région. Certains des services offerts aux Premières nations proviennent directement des ententes de contribution conclues avec la Direction générale de la santé des Premières nations et des Inuits. [...] Selon le genre et la portée des services, la*

18 20 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/27eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

19 21 avril 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-e/13evb-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

province conclura parfois une entente avec une Première nation en ce qui concerne des coûts particuliers relatifs à la santé[20].

Onalee Randell, directrice de la santé, Inuit Tapiriit Kanatami, explique que, pour les Inuits, le financement instable, incertain et de trop courte durée nuit à la mise en œuvre des programmes de santé mentale :

> *Quand finalement des initiatives ayant des échéanciers de trois à cinq ans sont mises en place dans les collectivités, le financement a cessé. Il est peu probable que des employés quittent un emploi permanent pour travailler dans un projet ne pouvant durer que deux ans. Il est donc très difficile de recruter du personnel compétent*[21].

Même le Programme de services de santé non assurés ne parvient pas à répondre aux besoins des populations ciblées. Mme Randell indique qu'une analyse des dépenses faites en 2003-2004 dans le cadre du volet intervention d'urgence du Programme de services de santé non assurés pour les Inuits a révélé que :

Des programmes et services liés à la toxicomanie, comme le Programme national de lutte contre l'abus d'alcool de drogues chez les Autochtones, sont entravés par des politiques qui ne tiennent aucun compte d'une croissance imprévue de population ou de la complexité des besoins.

> *[...] environ 60 000 $ ont été dépensés pour la santé mentale dans les collectivités inuites : 60 000 $ pour des collectivités qui enregistrent jusqu'à 11 fois la moyenne nationale du taux de suicide. Il semble y avoir une iniquité. Le programme est conçu pour offrir une consultation d'urgence à court terme. Certaines collectivités n'ont pas d'intervenants qui puissent faire ce type de consultation et, dans de nombreux cas, les collectivités préfèrent ignorer ces consultations d'urgence à court terme. Des personnes se présentent après un suicide, elles passent trois jours dans la collectivité puis s'en vont*[22].

Lorraine Boucher a dit au Comité que dans le cas des clients des Premières nations qui ont des problèmes de santé mentale ou de toxicomanie et qui doivent se rendre à l'extérieur de leur collectivité pour recevoir des services, le Programme des services de santé non assurés ne répond pas aux besoins :

> *Certains de nos membres ont dû mettre fin à leur thérapie à cause des compressions gouvernementales, dans le transport médical entre autres. Ces personnes sont oubliées par le système. Les frais de déplacement pour*

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20 1er juin 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/16evc-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

21 20 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/27eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

22 20 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/27eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

se rendre à Edmonton ou Peace River sont un fardeau qu'elles ne peuvent assumer seules[23].

Irene Linklater a aussi expliqué que des programmes et services liés à la toxicomanie, comme le Programme national de lutte contre l'abus d'alcool de drogues chez les Autochtones, sont entravés par des politiques qui ne tiennent aucun compte d'une croissance imprévue de population ou de la complexité des besoins :

Un Inuit qui veut avoir accès à des services de toxicomanie se heurte aux obstacles que créent les divisions administratives régionales au sein même de Santé Canada.

> *[S]i le Programme national de lutte contre l'abus d'alcool et de drogues chez les Autochtones n'a pas réussi à rester branché sur les besoins de la collectivité,c'est qu'on s'attendait à ce qu'il y ait des interventions visant des problèmes familiaux, par exemple la violence familiale, les tentatives de suicide, les personnes en situation de crise, et que l'on offrirait du soutien et des soins de suivi après un traitement et aussi qu'il y aurait un soutien communautaire après une tragédie*[24].

Selon Onalee Randell, un Inuit qui veut avoir accès à des services de toxicomanie se heurte aux obstacles que créent les divisions administratives régionales au sein même de Santé Canada :

> *Les Inuits de Nunatsiavut souhaitent travailler de concert avec les Inuits du Nunavik à élaborer un traitement de la toxicomanie axé sur la culture et les valeurs inuites. Pour l'instant, il est difficile de partager, l'information n'est pas la même au sein de chaque compétence. Les Inuits du Nunatsiavut l'obtiennent de la Région atlantique alors que ceux du Nunavik l'obtiennent de la région de Québec et jamais les deux ne se rencontreront*[25].

13.1.3.3 Confusion entre ministères et ordres de gouvernements

En plus des obstacles interministériels, les clients des Premières nations et des Inuits font souvent face à des difficultés causées par la division des responsabilités entre ministères fédéraux. Et la répartition des pouvoirs entre le fédéral et les provinces ou territoires crée d'autres obstacles encore et empêche de faire avancer les choses dans le domaine de la santé mentale.

Shawn Atleo, chef A-in-chut, chef régional de la C.-B., Assemblée des Premières nations, a déploré le manque de cohésion à l'échelle fédérale, indiquant que la semaine précédente, il

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23 20 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/27evb-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

24 1er juin 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/16evc-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

25 20 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/27eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

avait parlé à trois sous-ministres de trois ministères différents sur la situation du logement[26]. Jennifer Dickson, directrice exécutive, Pauktuutit Inuit Women's Association, a dit au Comité devoir transiger avec six ministères ou services fédéraux différents toutes les semaines pour divers programmes, politiques et projets[27].

Jules Picard, coordonnateur des services sociaux, Commission de la santé et des services sociaux des Premières nations du Québec et du Labrador, a illustré une situation de conflit entre ordres de gouvernement en citant le cas d'un jeune schizophrène qui a des démêlés avec la justice et a besoin d'une médication. Un problème a surgi quand il a été décrété que « Santé Canada ne pouvait pas payer la médication pour ce jeune parce qu'il faisait partie du réseau carcéral provincial »[28].

La répartition des pouvoirs entre le fédéral et les provinces ou territoires crée d'autres obstacles encore et empêche de faire avancer les choses dans le domaine de la santé mentale.

Susan Levi-Peters, chef de la Première nation d'Elsipogtog, Nouveau-Brunswick, a décrit l'extrême incertitude dans laquelle évoluent les gens qui cherchent à obtenir des fonds pour des services et tentent de déterminer s'il faut s'adresser aux Affaires indiennes, à Santé Canada ou à la province.

Il y a une extrême incertitude dans laquelle évoluent les gens qui cherchent à obtenir des fonds pour des services et tentent de déterminer s'il faut s'adresser aux Affaires indiennes, à Santé Canada ou à la province.

> *Quand nous nous adressons au gouvernement provincial, on nous répond que c'est un domaine de compétence fédérale. Le gouvernement fédéral nous dit de nous adresser à la province à qui il donne des fonds. Nous sommes les laissés pour compte*[29].

Ian Potter affirme qu'il y a actuellement une volonté des gouvernements d'intégrer leurs champs de compétence :

> *L'intégration des services fédéraux et des services provinciaux permettrait de réduire les services redondants ou l'incidence des services qui ne sont pas compatibles. Les services pourraient mieux répondre aux besoins des patients et le système ne serait plus fragmenté par les différences entre les juridictions*[30].

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26 20 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/27eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

27 20 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/27eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

28 21 juin 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/23evb-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

29 11 mai 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/15evf-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

30 20 avril 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/13eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

Cependant, Valérie Gideon, directrice des Services de santé et du développement social, Assemblée des Premières nations, se dit inquiète devant ces projets d'intégration :

> *À notre avis, cela pourrait être interprété comme une tentative de délestage des responsabilités fédérales sur d'autres administrations, chose contre laquelle nous avons souvent été mis en garde par les membres vivant dans les différentes régions et les différentes collectivités*[31].

Ian Potter signale aussi un besoin d'intégration interministérielle au sein même du gouvernement fédéral, entre Santé Canada et Affaires indiennes et du Nord Canada. Par exemple, pour accroître le personnel autochtone dans les services de santé, il soutient que les bourses d'études et de perfectionnement doivent être rattachées plutôt aux programmes d'enseignement offerts par Affaires indiennes et du Nord Canada, et commencer « à l'école primaire, afin que cela devienne une possibilité réelle pour les Autochtones ».

Le vérificateur général du Canada a souvent reproché à Santé Canada et à Affaires indiennes et du Nord Canada de n'avoir pas établi de pouvoir législatif clair en ce qui concerne les programmes et services offerts aux Premières nations et aux Inuits. Plus précisément, le vérificateur général constate que l'absence d'une loi habilitante particulière pour le programme des Services de santé non assurés « avait laissé une lacune dans les définitions de l'objet, des résultats escomptés et des retombées du programme ». Il était recommandé à Santé Canada de demander au gouvernement « un mandat renouvelé pour ce programme afin d'en clarifier l'autorisation, le but et l'objectif »[32].

Le vérificateur général indique que si la *Loi sur les Indiens* donne les critères permettant de déterminer qui est un « Indien inscrit » et quelles sont les obligations du fédéral à l'égard des populations autochtones prises collectivement, elle ne précise pas les programmes et services qui doivent leur être offerts. On rappelle à Affaires indiennes et du Nord Canada de même qu'au Parlement que :

> *L'absence d'autorisation législative formelle pourrait miner le contrôle parlementaire et la reddition des comptes. Elle empêche le Parlement de débattre de questions importantes comme celles de savoir si un programme d'assistance sociale pour les Indiens vivant dans les réserves devrait permettre à la fois de réduire la demande et de fournir les services et de déterminer quelles devraient être les prestations appropriées. Elle le prive aussi d'un instrument qui lui permettrait de demander au*

31 21 juin 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/23evb-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

32 Vérificateur général du Canada, Santé Canada — Santé des Premières nations, ch. 13, octobre 1997 http://www.oagbvg.gc.ca/domino/reports.nsf/html/ch9713e.html#0.2.L39QK2.4FNW9F.4QDJQE.ZG.

Ministère de lui rendre des comptes en se fondant sur des autorisations de programme autres que celles approuvées par le Conseil du Trésor[33].

13.1.4 Commentaire du Comité

Comme nous l'avons dit plus haut, le prochain chapitre (chapitre 14) traitera du besoin de mettre en place une approche globale pour traiter des besoins de santé mentale des populations autochtones. C'est là que nous ferons valoir l'importance de créer un comité consultatif national autochtone qui fasse partie de la Commission canadienne de la santé mentale. Il y sera aussi question de transparence dans le compte rendu des activités, par l'intermédiaire d'un comité fédéral interministériel formé des sous-ministres responsables de tous les programmes et services destinés aux populations autochtones.

Le *Plan directeur pour la santé des Autochtones* déposé à la rencontre des premiers ministres des provinces en novembre 2005 réitère la volonté déjà exprimée de préciser les rôles et responsabilités respectifs du gouvernement fédéral et des gouvernements provinciaux et territoriaux[34]. Mais les Premières nations et les Inuits ont déjà une longue tradition de rapports avec le fédéral et la multi-dimensionnalité de leurs besoins justifie qu'ils fassent l'objet d'une attention particulière de la part des institutions fédérales. Le Comité a très bien compris que si des initiatives fédérales ont été et sont actuellement orientées vers la santé mentale des Premières nations et des Inuits, les programmes et services fédéraux n'ont pas donné les résultats escomptés. Le Comité constate l'existence d'un écart considérable entre les engagements financiers du gouvernement fédéral et les résultats concrets dont les Premières nations et les Inuits ont pu bénéficier.

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Le Comité estime qu'une tribune indépendante et objective devrait porter son regard sur l'ensemble des besoins de santé mentale des Premières nations et des Inuits, et agir un peu comme un ombudsman

Le Comité estime qu'une tribune indépendante et objective devrait porter son regard sur l'ensemble des besoins de santé mentale des Premières nations et des Inuits, et agir un peu comme un ombudsman, habilité à faire enquête et à tenir le gouvernement responsable de la réalisation des programmes et services nécessaires, ainsi que des résultats obtenus.

D'autres groupes de clients fédéraux, tels les délinquants sous responsabilité fédérale, les membres des Forces canadiennes et les membres de la GRC, ont déjà accès à une telle instance habilitée à faire enquête, à formuler des recommandations et à veiller à ce que des correctifs soient apportés. Les Premières nations et les Inuits ont besoin de pouvoir s'adresser à une instance de ce genre pour faire entendre leurs griefs dans leurs rapports avec

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33 Vérificateur général du Canada, Affaires indiennes et du Nord Canada —Assistance sociale, 1994, http://www.oagbvg.gc.ca/domino/reports.nsf/html/9423ce.html#0.2.L39QK2.6NA0GI.V1SJQE.ZL.

34 Santé Canada, Plan directeur de la santé des Autochtones : un plan de transformation sur dix ans, préparé pour la réunion entre les premiers ministres et les dirigeants d'organisations autochtones nationales, 24-25 novembre 2005, un travail en constante évolution http://www.hc-sc.gc.ca/hcs-sss/pubs/care-soins/2005-blueprint-plan-abor-auto/index_f.html.

les ministères fédéraux qui jouent un rôle si important dans tout ce qui a trait à leur santé tant mentale que physique.

Par conséquent, le Comité recommande :

(58)	**Que le gouvernement fédéral crée, pour les Premières nations et les Inuits, une instance fédérale semblable à celle de l'Enquêteur correctionnel, de l'Ombudsman des Forces canadiennes ou du Comité externe d'examen de la GRC.** **Que cette instance soit habilitée à enquêter sur des plaintes individuelles de même que sur diverses préoccupations générales portant sur la prestation même des programmes et services fédéraux ayant une incidence sur la santé mentale des Premières nations et des Inuits.** **Que le ou la responsable de cette instance soit, si possible, d'origine autochtone.** **Que cette instance fasse rapport tous les ans au Parlement.**

Le Comité a été consterné d'apprendre qu'en vertu du *Plan directeur pour la santé des Autochtones* de 2005, le rapport détaillé des résultats combinés des programmes fédéraux et provinciaux et des sommes consacrées à la santé mentale des Premières nations, des Inuits et des Métis ne sera pas déposé avant 2010-2011.

Le Comité a été consterné d'apprendre qu'en vertu du *Plan directeur pour la santé des Autochtones* de 2005, le rapport détaillé des résultats combinés des programmes fédéraux et provinciaux et des sommes consacrées à la santé mentale des Premières nations, des Inuits et des Métis ne sera pas déposé avant 2010-2011[35]. Pour le moment, les données produites par Affaires indiennes et du Nord Canada et Santé Canada sont limitées et ne portent que sur les Premières nations. Par exemple, l'information sur les dépenses engagées utilise le terme combiné de « Premières nations et Inuits » et ne dit pas quelles sommes ont été allouées à chaque groupe; on présume que les dépenses sont proportionnelles à la taille de la population de chaque groupe. Il n'y a aucune donnée utile permettant d'évaluer les programmes et services destinés aux Inuits puisque les données sont fusionnées à celles des Premières nations et des autres populations autochtones.

Il n'y a aucune donnée utile permettant d'évaluer les programmes et services destinés aux Inuits puisque les données sont fusionnées à celles des Premières nations et des autres populations autochtones.

Bien que le gouvernement fédéral se soit engagé à produire des rapports complets fondés sur des indicateurs de santé distincts, propres à chaque groupe autochtone, le Comité craint que le Parlement et les ministères continuent encore pendant cinq ans à prendre des décisions sans disposer d'une information complète.

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35 *Ibid.*

Par conséquent, le Comité recommande :

70	**Que Affaires indiennes et du Nord Canada, Santé Canada et tout autre ministère ayant la responsabilité directe de programmes ou de services offerts aux Premières nations et aux Inuits établissent un relevé annuel de leurs programmes et services respectifs, pour l'année en cours et les cinq dernières années.** **Que ce relevé comprenne une description claire de chaque programme ou service, par exercice; des critères d'admissibilité; du nombre respectif de clients des Premières nations et des Inuits desservis par le programme, par lieu géographique; des budgets consentis et des sommes dépensées; ainsi que toute évaluation ayant été réalisée des résultats obtenus relatifs aux facteurs déterminants de la santé mentale.** **Que ce relevé soit soumis au Parlement tous les ans à compter de 2008.**

Le gouvernement fédéral a eu amplement le temps de créer des lois pour préciser son rôle et ses responsabilités et d'élaborer des politiques capables de réduire la confusion interministérielle. L'heure est venue d'agir de façon à corriger la fragmentation interministérielle qui contribue au piètre état de santé des Premières nations et des Inuits.

Mais surtout, le Comité estime que la configuration actuelle des ministères fédéraux, avec leurs fondements législatifs et politiques respectifs, ne fait rien pour améliorer le sort des Premières nations et des Inuits. Depuis que la responsabilité et l'administration des services médicaux offerts aux Indiens et aux Inuits sont passées du ministère des Affaires indiennes au ministère de la Santé nationale et du Bien-être social en 1945, l'état de santé de cette population s'est bien peu amélioré. Le gouvernement fédéral a eu amplement le temps de créer des lois pour préciser son rôle et ses responsabilités et d'élaborer des politiques capables de réduire la confusion interministérielle. L'heure est venue d'agir de façon à corriger la fragmentation interministérielle qui contribue au piètre état de santé des Premières nations et des Inuits.

Le Comité estime que les services actuellement offerts par Affaires indiennes et du Nord Canada dans les secteurs du logement, de l'éducation et du soutien du revenu doivent être rattachés aux services offerts par Santé Canada dans les secteurs de la promotion de la santé chez les enfants et des facteurs d'adaptation qui permettent de réduire la toxicomanie et le suicide.

Le Comité est absolument convaincu qu'une approche globale est essentielle au renforcement de la santé mentale chez les Premières nations et les Inuits. La division des programmes et des services entre Santé Canada et Affaires indiennes et du Nord Canada n'a aucun sens. Le Comité estime que les services actuellement offerts par Affaires indiennes et du Nord Canada dans les secteurs du logement, de l'éducation et du soutien du revenu doivent être rattachés aux services offerts par Santé Canada dans les secteurs de la promotion de la santé chez les enfants et des facteurs d'adaptation qui permettent de réduire la toxicomanie et le suicide. À l'heure actuelle, les programmes et services sont mal coordonnés et les ministères rivalisent

entre eux pour l'obtention des budgets. Il faut un changement radical pour que les Premières nations et les Inuits reçoivent une gamme complète de programmes et services axés sur les facteurs déterminants de la santé et donnant des résultats favorables. Il faut une réelle transformation de la situation actuelle, non pas seulement des retouches superficielles.

Le Comité reconnaît toutefois qu'un changement du mode de prestation des programmes et services qui prend appui sur une base législative claire exige un examen approfondi de toutes les approches possibles et de leurs retombées. Le Comité recommande donc que le gouvernement fédéral procède à un examen objectif et indépendant des meilleurs moyens d'offrir les programmes et services essentiels à la promotion et au maintien de la santé des Premières nations et des Inuits, et prenne le temps de réfléchir aux mesures législatives nécessaires. Pour le moment, le Comité ne peut se prononcer avec certitude sur laquelle des approches suivantes serait la meilleure :

- doit-on conserver les structures actuelles en modifiant considérablement la façon dont Santé Canada et Affaires indiennes et du Nord Canada offrent les programmes et services;
- les responsabilités de la Direction générale de la santé des Premières nations et des Inuits de Santé Canada devraient-elles être transférées à Affaires indiennes et du Nord Canada; ou
- certaines ressources précises, assorties de tous les critères d'évaluation et de responsabilisation nécessaires, devraient-elles être transférées soit aux Premières nations et aux Inuits eux-mêmes, ou aux gouvernements des provinces et des territoires?

Le Comité recommande :

71	**Que le gouvernement fédéral fasse immédiatement réaliser une étude indépendante des modalités fédérales de prestation des programmes et services se rapportant à la santé des Premières nations et des Inuits dans son ensemble.** **Que cette étude envisage diverses possibilités de prestation de ces services; fasse une évaluation claire de ces possibilités; et aboutisse au dépôt d'un rapport complet au Parlement, assorti de recommandations, en 2008.**

13.2 LES DÉLINQUANTS SOUS RESPONSABILITÉ FÉDÉRALE

[L]a pratique cruelle qui consiste à incarcérer les personnes souffrant de maladie mentale dans des prisons est inhumaine, injuste et inefficace. Les prisons ne disposent pas des installations appropriées ni des ressources médicales nécessaires pour accueillir les personnes atteintes de maladie mentale. Le personnel manque souvent de compétence et est incapable de

composer avec les difficultés de la maladie mentale. Les personnes atteintes ont des pensées illogiques, des délires, des hallucinations auditives, elles souffrent de paranoïa et ont de graves sautes d'humeur; elles ne comprennent pas toujours les règles des prisons. Elles sont très vulnérables et sont susceptibles d'avoir un comportement bizarre avec lequel le personnel de la prison doit composer et que les codétenus doivent tolérer. — Bonita Allen, mère d'un fils bipolaire[36]

13.2.1 La compétence fédérale

Une comparaison entre les admissions dans les établissements fédéraux en 1967 et en mars 2004 fait apparaître une augmentation de 60 p. cent du nombre de détenus atteints de troubles mentaux.
— *Howard Sapers*

Service correctionnel Canada (SCC) administre les peines imposées par les tribunaux dont la durée est de deux ans ou plus. La *Loi canadienne sur la santé* exclut explicitement « [l]es personnes purgeant une peine d'emprisonnement dans un pénitencier, au sens de la Partie I de la *Loi sur le système correctionnel et la mise en liberté sous condition* » de la définition des personnes assurées en vertu des régimes provinciaux de soins de santé[37]. Le gouvernement fédéral est directement responsable de la prestation de services de santé aux détenus des établissements fédéraux.

En 1992, la *Loi sur le système correctionnel et la mise en liberté sous condition* (LSCMLC) a remplacé la *Loi sur les pénitenciers*. La LSCMLC définit les « soins de santé mentale » et exige que chaque détenu reçoive les soins de santé essentiels et qu'il ait « accès, dans la mesure du possible, aux soins [de santé mentale] qui peuvent faciliter sa réadaptation et sa réinsertion sociale »[38]. Une Directive du commissaire du SCC sur les services de santé indique que les services essentiels comprennent « les services actifs et prolongés de soins de santé mentale »[39]. La Loi oblige aussi à tenir compte de « l'état de santé du délinquant et des soins qu'il requiert » au moment de prendre une décision relative à son placement, son transfert, son isolement préventif ou aux mesures préparatoires à sa mise en liberté et sa surveillance.

Le Rapport sur le rendement du Service correctionnel du Canada, pour la période se terminant en mars 2005, affirme que :

> Au cours d'une journée type, en 2004-2005, le SCC avait la charge d'environ 12 600 délinquants détenus dans un établissement fédéral

36 6 juin 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/18eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

37 Loi canadienne sur la santé, 1984, ch. C-6, art. 2 — Définitions, http://ois.justice.gc.ca/fr/C-6/183585.html#rid-183588.

38 Loi sur le système correctionnel et la mise en liberté sous condition, 1992, ch. 20, http://lois.justice.gc.ca/fr/C-44.6/.

39 Service correctionnel Canada, Directive du commissaire, « Services de santé » numéro 800, 2004, http://www.csc-scc.gc.ca/text/plcy/cdshtm/800-cde_f.shtml.

et d'environ 8 200 délinquants purgeant une partie de leur peine sous surveillance dans la collectivité[40].

Francoise Bouchard, directrice générale, Services de santé, Service correctionnel Canada, a déclaré qu'un grand nombre de délinquants ont des problèmes de santé mentale.

> *Douze pour cent sont atteints de troubles mentaux graves qui nécessitent une intervention immédiate. Le pourcentage des délinquants chez qui on a diagnostiqué un trouble mental au moment de leur admission a augmenté de 61 p. cent en sept ans. De plus, au cours de cette même période, le nombre de délinquants qui prennent des médicaments sur ordonnance a augmenté de 80 p. cent*[41].

Howard Sapers, l'enquêteur correctionnel du Canada, mandaté par la *Loi sur le système correctionnel et la mise en liberté sous condition* pour agir en qualité de médiateur pour les délinquants fédéraux, a lui aussi fait état de la forte prévalence des cas de maladie mentale et de toxicomanie chez les détenus :

Près de la moitié de ceux qui présentent un problème d'abus de substances ont aussi d'autres problèmes; le taux de suicide est beaucoup plus élevé parmi les détenus que dans la population générale.

Environ 22 p. cent des délinquants adultes seraient atteints de TSAF .

> *Une comparaison entre les admissions dans les établissements fédéraux en 1967 et en mars 2004 fait apparaître une augmentation de 60 p. cent du nombre de détenus atteints de troubles mentaux. La ventilation par sexe est la suivante : 57 p. cent d'hommes et 65 p. cent de femmes. La prévalence passe à près de 84 p. cent si l'on englobe dans ces chiffres l'abus de substances*[42].

Près de la moitié de ceux qui présentent un problème d'abus de substances ont aussi d'autres problèmes; le taux de suicide est beaucoup plus élevé parmi les détenus que dans la population générale. En ce qui concerne le syndrome d'alcoolisme fœtal, Howard Sapers dit que les « chiffres obtenus auprès des établissements pour jeunes à travers le Canada estiment qu'environ 22 p. cent des délinquants adultes seraient atteints de TSAF »[43].

13.2.2 Programmes et services fédéraux

Service correctionnel Canada établit une distinction entre les programmes courants destinés à la population générale des détenus qui ne sont pas atteints de maladie mentale, et les

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40 Service correctionnel Canada, Rapport sur le rendement pour la période se terminant le 31 mars 2005, http://www.tbs-sct.gc.ca/rma/dpr1/04-05/CSC-SCC/CSC-SCCd45_f.pdf.

41 23 février 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/08ev-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

42 7 juin 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/19eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

43 7 juin 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/19eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

programmes spéciaux destinés à ceux qui ont besoin de services de santé mentale notamment pour cause de personnalité anti-sociale[44].

Bien que la capacité actuelle d'évaluer et de prendre en charge les problèmes de santé mentale des délinquants soit limitée, SCC travaille à élaborer un éventail de soins de santé mentale axé sur quatre secteurs clés[45] :

- évaluation complète de la santé mentale des délinquants au moment de l'admission afin d'établir des plans de traitement appropriés, de placer les délinquants dans les établissements les plus adéquats, et de recueillir des données pour faciliter la planification;

- centres régionaux de traitement (il y en a actuellement cinq) satisfaisant aux exigences relatives au statut d'établissement hospitalier, à l'agrément, au nombre et au type d'employés, aux critères d'admission et au niveau de sécurité, qui savent cibler la clientèle ayant besoin de traitements particuliers (notamment les cas de TSAF et de troubles de la personnalité);

La Stratégie en matière de santé mentale, approuvée par le SCC à l'été de 2004, est restée en plan.

- services de santé mentale offerts dans les établissements ordinaires et création d'unités de santé mentale offrant des soins intermédiaires dans certains établissements pour desservir les détenus qui, sans avoir besoin d'être hospitalisés, requièrent un encadrement plus rigoureux et un soutien plus ferme;

- stratégie de santé mentale dans la collectivité pour continuer de dispenser des soins aux délinquants quand ils sont remis en liberté, notamment des services spécialisés et des services de soutien en matière d'emploi, de logement et de santé mentale.

En novembre 2005, le Rapport annuel de l'Enquêteur correctionnel pressait Service correctionnel Canada d'engager les fonds nécessaires pour mettre en œuvre sa *Stratégie en matière de santé mentale* :

Dans les faits, les soins de santé mentale ne sont pas offerts dans les centres de réception, les centres de traitement ou les centres de services communautaires.

> La Stratégie, approuvée par le SCC à l'été de 2004, est restée en plan. Aucun financement n'a été engagé pour mettre en place les trois composantes initiales du plan d'action : processus complet d'évaluation clinique à l'admission; amélioration des centres de traitement actuels du Service et mise sur pied d'unités intermédiaires de soins en santé mentale au sein des pénitenciers existants pour traiter et évaluer les délinquants tout au long de leur

44 Pour plus de renseignements sur la question de la santé mentale, voir Dr Brent Moloughney, « Évaluation des besoins en soins de santé des détenus sous responsabilité fédérale » Revue canadienne de santé publique, vol. 95, supplément 1, mars/avril 2004, http://www.cpha.ca/english/cjph/inmates/CJPH_95_Suppl_1_e.pdf.

45 23 février 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/08ev-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

> incarcération. Quant au financement obtenu pour aller de l'avant avec la quatrième composante, c'est-à-dire offrir des services de santé mentale dans la collectivité pour aider les délinquants en liberté, il n'a toujours pas été confié aux collectivités[46].

Bien que l'objectif de la politique, tel qu'il est énoncé dans la Directive du commissaire sur les Services de santé, soit de « s'assurer que les détenus ont accès aux services médicaux, dentaires et de santé [mentale] essentiels, conformément aux pratiques généralement admises dans la collectivité », dans les faits, les soins de santé mentale ne sont pas offerts dans les centres de réception, les centres de traitement ou les centres de services communautaires[47].

13.2.2.1 Centres de réception

La Directive stipule, en ce qui concerne les normes de soins à la réception, que dans les deux jours ouvrables suivant son arrivée, tout détenu doit subir une évaluation infirmière portant sur les problèmes aigus de santé physique et mentale. Toutefois, le but premier de l'évaluation préliminaire de santé mentale est d'établir le niveau de risque que pose le détenu plutôt que la détermination complète de ses besoins de santé mentale. Une évaluation du risque de suicide est aussi faite à l'arrivée. Si la personne est suicidaire, elle est placée sous observation pendant un certain temps, puis réévaluée. Une évaluation infirmière complète doit avoir lieu dans les 14 jours suivant l'admission.

Le but premier de l'évaluation préliminaire de santé mentale, toutefois, est d'établir le niveau de risque que pose le détenu plutôt que la détermination complète de ses besoins de santé mentale.

Les délinquants résident au centre de réception pendant les trois premiers mois de leur incarcération et y reçoivent les soins médicaux nécessaires. Si la personne a besoin d'une médication en raison d'un problème de santé mentale, l'infirmière peut l'adresser au médecin de l'établissement pour examen. Si un problème de comportement se produit, une évaluation par un psychologue peut être exigée. Les délinquants peuvent aussi rencontrer un psychiatre au centre de réception.

13.2.2.2 Centres de traitement

Si des problèmes de santé mentale sérieux se manifestent pendant le séjour du détenu à l'unité de réception, ou si un diagnostic précis a pu être établi à l'accueil, le détenu peut être admis dans l'un des cinq centres de traitement régionaux. Ces centres offrent aussi des programmes destinés aux délinquants sexuels et aux délinquants violents.

Bien que la continuité des soins soit le but visé, peu de délinquants fédéraux reçoivent les traitements dont ils ont besoin par manque des services nécessaires en santé mentale.

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46 Bureau de l'enquêteur correctionnel, communiqué de presse, « Hausse dramatique du nombre de détenus ayant une maladie mentale — Mise en œuvre d'une stratégie nationale pour régler la situation d'urgence », 4 novembre 2005, http://www.oci-bec.gc.ca/release-20051104_f.asp.

47 Service correctionnel Canada, Directive du commissaire, « Services de santé » numéro 800, 2004, http://www.csc-scc.gc.ca/text/plcy/cdshtm/800-cde_f.shtml.

Dans les centres de traitement, les services de santé sont offerts 24 heures par jour. L'état de la personne est stabilisé, sa médication est analysée, et une évaluation est faite pour déterminer si un transfert dans un établissement ordinaire est possible. Avant le transfert, le dossier médical est passé en revue afin de déterminer tous les problèmes de santé et assurer ainsi la continuité des soins et la capacité du détenu de s'inscrire dans les programmes réguliers offerts à l'établissement d'accueil.

Bien que la continuité des soins soit le but visé, peu de délinquants fédéraux reçoivent les traitements dont ils ont besoin par manque des services nécessaires en santé mentale.

13.2.2.3 Établissements ordinaires

Une fois son état stabilisé et le délinquant affecté à un établissement ordinaire, à sécurité minimale, moyenne ou maximale, son état de santé est examiné par le personnel médical. Il n'y a cependant ni budget réservé ni services spécialisés en santé mentale.

13.2.2.4 Services de santé communautaires

Les délinquants en liberté conditionnelle totale, en liberté d'office ou en semi-liberté qui vivent dans un centre résidentiel communautaire, ont accès aux services de santé essentiels couverts par le régime provincial d'assurance-maladie. La planification prélibératoire comprend une demande de carte d'assurance-maladie.

Les délinquants qui vivent dans un Centre correctionnel communautaire reçoivent les services de santé essentiels à la charge de Service correctionnel Canada. Le SCC doit aussi payer « les autres services de santé non assurés du délinquant résidant dans un centre correctionnel communautaire ou un centre résidentiel communautaire, qui ne travaille pas, qui n'a aucune autre source de revenu, et qui n'est par ailleurs admissible à aucune autre forme d'aide communautaire ou gouvernementale »[48]. Le Service doit aussi payer « les traitements de santé mentale qui ne sont pas assurés, que demande la Commission nationale des libérations conditionnelles ou le Plan correctionnel, pour tout délinquant en liberté conditionnelle ».

13.2.3 Évaluation des besoins du groupe client

13.2.3.1 Établissement

Les témoins ont exprimé des doutes sérieux quant à la capacité des cinq établissements de traitement de Service correctionnel Canada de répondre aux besoins des délinquants ayant des problèmes de santé mentale. Howard Sapers a déclaré que :

Les témoins ont exprimé des doutes sérieux quant à la capacité des cinq établissements de traitement de Service correctionnel Canada de répondre aux besoins des délinquants ayant des problèmes de santé mentale.

> *Le SCC a actuellement des lits disponibles dans ses centres de traitement pour répondre aux besoins de moins de 6 p. cent de la population carcérale. Or, selon les estimations*

[48] *Ibid.*

du service lui-même, le besoin est pour environ 12 p. cent. Ainsi, la capacité actuelle est inférieure à 50 p. cent du besoin identifié[49].

Natalie Neault, directrice des enquêtes, Bureau de l'enquêteur correctionnel du Canada, a affirmé que certains centres de traitement ne pouvaient offrir de services aux détenus à sécurité maximale. Elle a parlé de douze détenus placés en isolement de longue durée et présentant des symptômes avérés de maladie mentale, à qui on a refusé plusieurs fois l'admission au Centre de traitement Shepody de Dorchester (Nouveau-Brunswick), sous prétexte que celui-ci n'avait pas la structure nécessaire pour recevoir des détenus à sécurité maximale. Dans ce cas, quand un détenu reçoit la visite d'un psychologue, le but de cette visite n'est pas de traiter la maladie mentale mais d'évaluer le risque de suicide :

Les envoyer dans une autre région, loin de leurs proches — qui sont souvent leur seul soutien lui-même souvent très réduit — est contraire à tout l'objectif de la réinsertion de ces personnes. Ils restent donc dans ces unités d'isolement, voyant un psychologue une fois par mois pour vérifier qu'ils ne sont pas suicidaires[50].

Robert Miller, chef du service de psychiatrie au *Vancouver Island Health Authority* soutient que les établissements et services offerts aux détenus qui présentent des besoins de santé mentale devraient répondre aux mêmes normes que ceux qui sont offerts à la population générale :

Les établissements et services offerts aux détenus qui présentent des besoins de santé mentale devraient répondre aux mêmes normes que ceux qui sont offerts à la population générale

[...] que les personnes ayant besoin d'être soignées à l'hôpital soient hospitalisées, au lieu d'être soignées en prison. De plus, dans les établissements correctionnels où des soins sont assurés, il n'est pas nécessaire d'hospitaliser tout le monde. En milieu carcéral, il est tout à fait possible d'assurer des services de santé mentale en consultation externe, mais les soins et les traitements qu'on y dispense devraient être de la même qualité que ceux disponibles dans la collectivité locale[51].

13.2.3.2 Intégration communautaire

Dans le cas des délinquants qui ont fait l'objet d'un diagnostic de maladie mentale, qui sont sous traitement et ont besoin d'être suivis par un psychiatre, Service correctionnel Canada tente d'assurer la continuité des services après la remise en

L'impossibilité d'intégrer ou simplement de coordonner les services relevant d'organismes fédéraux et provinciaux fait que certaines personnes n'ont pas la médication qu'il leur faut et risquent de récidiver.

49 7 juin 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/19eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

50 7 juin 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/19eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

51 7 juin 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/19evb-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

liberté. Il faut à cette fin trouver un psychiatre, une clinique ou un hôpital qui acceptera de voir le délinquant après sa libération, et intégrer des services communautaires dans le plan de libération. Des problèmes peuvent survenir si le délinquant décide de ne pas se présenter à ses rendez-vous ou à la clinique, si les services n'acceptent pas de recevoir le délinquant, ou si les services ne sont pas offerts où et quand la libération doit avoir lieu. Si le délinquant réside dans un centre correctionnel communautaire, les services sont maintenus tant qu'il relève des services correctionnels.

Dans la réalité, les interventions et les services communautaires sont limités en raison de l'ostracisme dont sont frappés les anciens détenus et les personnes atteintes de maladie mentale. Michael Bettman, directeur général par intérim, Programmes pour délinquants et réinsertion sociale, Service correctionnel Canada, indique que l'ostracisme est le principal obstacle à la réinsertion sociale :

> *Notre principal obstacle reste, dans une grande mesure, l'ostracisme. Ces délinquants font partie de notre collectivité mais les gens refusent d'accepter ce fait. Ils veulent les isoler non seulement quand ils sont en prison mais aussi quand ils sont dans les collectivités; ils affirment que le traitement des maladies mentales relève du gouvernement et non pas de la ville et, par conséquent, nous sommes souvent laissés à nous-mêmes quand nous tentons de répondre aux besoins de ces délinquants*[52].

L'impossibilité d'intégrer ou simplement de coordonner les services relevant d'organismes fédéraux et provinciaux fait que certaines personnes n'ont pas la médication qu'il leur faut et risquent de récidiver. Bernard Galerneau, psychologue, directeur politique, Centre de rétablissement Shepody, signale que :

> *Les détenus atteints de troubles mentaux qui prennent des médicaments psychotropes reçoivent généralement, au moment de leur libération, une provision de médicaments pour deux semaines. Combien de temps doivent-ils attendre avant de voir un médecin ou un psychiatre qui renouvellera leur ordonnance*[53]*?*

Jocelyn Greene, directrice exécutive, Stella Burry Community Services, a parlé d'un programme de soutien communautaire très innovateur, inspiré du modèle familial et destiné aux femmes présentant des problèmes de santé mentale complexes, qui semble offrir de belles perspectives d'économies tant pour le système carcéral que pour le système de soins de santé :

> *L'évaluation du programme a montré qu'il y avait eu une réduction considérable des taux d'hospitalisation et d'incarcération. [...] le point saillant est la diminution du nombre de jours de prison, qui était de*

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52 23 février 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/08ev-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

53 11 mai 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/15evf-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

73 p. cent, et la diminution des jours d'hospitalisation, qui était de 39,2 p. cent[54].

13.2.3.3 Ressources humaines

Il est d'autant plus difficile de réunir les ressources humaines nécessaires à la prestation des services de santé mentale que les professionnels se voient imposer une multitude de tâches. Françoise Bouchard a indiqué qu'il y a :

Bien que les détenus en isolement soient censés voir un psychologue une fois par mois, ce n'est tout simplement pas possible.

> *[...] environ 250 psychologues qui travaillent pour le Service correctionnel du Canada. Cependant, il ne faut pas oublier que les psychologues ne fournissent pas uniquement des services de santé mentale. Ils effectuent également une évaluation des risques pour les autorités correctionnelles. En fait, l'essentiel des activités des psychologues de SCC ont trait à l'évaluation des risques*[55].

Bernard Galarneau, psychologue institutionnel au Centre de rétablissement Shepody, a expliqué que la charge de travail est très lourde et qu'on accorde plus d'importance à l'évaluation des risques qu'à la santé mentale :

> *Comme nous nous occupons de 100 à 200 détenus, nous ne pouvons consacrer que très peu de temps à la véritable psychothérapie. On agit comme un urgentologue, on gère les crises au fur et à mesure qu'elles éclatent et on fait beaucoup d'évaluation des risques*[56].

Bien que les détenus en isolement soient censés voir un psychologue une fois par mois, Natalie Neault indique que ce n'est tout simplement pas possible :

> *[I]l y a une liste longue comme mon bras de détenus en attente de services psychologiques et les ressources sont très limitées. Il y a seulement deux psychologues pour une population de presque 300 détenus*[57].

Christine Davis, présidente, Fédération canadienne des infirmières et infirmiers en santé mentale, demande que les infirmières reçoivent plus de formation et aient à jouer un rôle plus étendu :

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54 15 juin 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/22evb-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

55 23 février 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/08ev-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

56 11 mai 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/15evf-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

57 7 juin 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/19eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

> *Si on leur donnait la formation appropriée, les infirmières et les infirmiers qui travaillent en milieu carcéral pourraient jouer un rôle plus actif en matière d'évaluation de la santé mentale, de méthodes de traitement fondées sur l'expérience clinique et de soins à long terme des détenus souffrant de problèmes de santé mentale. Trop souvent, les gens sont détenus faute de place dans les établissements de médecine légale. Si les infirmières qui fournissent des soins physiques bénéficiaient d'un soutien pour faire des évaluations de santé mentale et apporter des traitements, il y aurait moins de pression sur les établissements de médecine légale et les personnes qui sont dans le système de justice et qui sont affectées par la maladie mentale pourraient être dirigées vers les soins appropriés en temps opportun*[58].

Certains témoins, comme Kim Pate, directrice exécutive, Association canadienne des sociétés Elizabeth Fry, reconnaît qu'il n'est pas possible de former tout le personnel afin qu'il puisse faire des évaluations de santé mentale, mais elle insiste sur l'extrême importance de repérer les délinquants qui présentent des problèmes de santé mentale et de leur offrir rapidement les soins dont ils ont besoin. Elle dit que des patientes s'améliorent parfois très rapidement lorsqu'elles sont « vues par la lorgnette de la santé mentale plutôt que par celle de la criminalité »[59]. Pour Howard Sapers, le personnel doit avoir appris à « faire la différence entre une crise de santé mentale et une crise sécuritaire face à un détenu qui perd les pédales »[60].

13.2.3.4 Groupes particuliers — isolement, femmes, Autochtones

Les détenus en isolement risquent plus que les autres de faire l'objet d'une évaluation insuffisante et leurs besoins de santé mentale risquent fort de ne pas être pleinement reconnus. Howard Sapers dit que les détenus en isolement, qui sont enfermés jusqu'à 23 heures par jour dans les établissements à sécurité maximale, sont souvent atteints de déficience intellectuelle ou présentent « des problèmes de comportement, des difficultés d'apprentissage et (ou) des symptômes d'hyperactivité avec déficit de l'attention, HADA, ou alcoolisme fœtal, TSAF ». Il a brossé un tableau plutôt sombre du sort réservé à ces détenus dans le système carcéral :

Les détenus en isolement risquent plus que les autres de faire l'objet d'une évaluation insuffisante et leurs besoins de santé mentale risquent fort de ne pas être pleinement reconnus.

Natalie Neault a expliqué l'importance de bien évaluer dès l'accueil les détenus qui présentent des difficultés d'apprentissage car ils « ont du mal à suivre les ordres des agents et gardiens, se retrouvent inculpés, placés en isolement et sujets à des sanctions disciplinaires

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58 20 avril 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/13eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

59 16 février 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/06eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

60 7 juin 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/19eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

Ces contrevenants sont incapables de suivre des programmes ordinaires, ils sont la proie d'autres détenus, ils aboutissent en isolement, ils ont une capacité limitée à faire face et ils sont habituellement classés comme à sécurité maximale. Ils n'ont pas la capacité ou les aptitudes pour se concentrer et suivre les programmes réguliers. Ils sont vulnérables et leur ségrégation est généralement plus longue que celle des autres détenus en isolement. On les envoie habituellement voir le psychiatre, qui typiquement ne trouve pas d'indice de trouble psychiatrique, et les caractérise comme présentant un problème de comportement. Ces délinquants ne remplissent donc pas les critères qui leur permettraient de bénéficier des services d'un centre de traitement, et ils restent confinés dans des établissements généraux. Ils ont des facultés d'adaptation limitées, ce qui peut les amener à se couper d'autrui, se mutiler, mettre le feu, se suicider ou tenter de le faire et, dans quelques situations extrêmes, agresser d'autres détenus ou des gardiens[61].

Quelques témoins ont demandé que le personnel soit formé de manière à mieux pouvoir intervenir auprès de délinquants présentant des troubles qui risquent de les conduire en isolement, et qu'une formation soit offerte au personnel qui travaille avec les détenus en isolement. Natalie Neault a expliqué l'importance de bien évaluer dès l'accueil les détenus qui présentent des difficultés d'apprentissage car ils « ont du mal à suivre les ordres des agents et gardiens, se retrouvent inculpés, placés en isolement et sujets à des sanctions disciplinaires »[62]. Kim Pate a décrit son expérience de travail auprès de femmes placées en isolement :

Les femmes avaient été particulièrement touchées par la désinstitutionnalisation de même que pas les coupures dans les programmes sociaux, ce qui donne à croire que pour certaines femmes, la prison est devenue une sorte de système de soins de remplacement.

Vous ne pouvez imaginer le nombre de fois que j'ai dû me mettre à genoux devant une cellule d'isolement pour parler à une détenue par le passe-plat, et essayer de la convaincre d'arrêter de se taper la tête contre le mur et m'entendre dire par un membre du personnel qu'on lui avait dit de compter jusqu'à 20, parce qu'après 20 on n'a plus affaire à une tactique pour attirer l'attention, mais que c'est peut-être une question de vie ou de mort. Ce n'est pas que le personnel soit mal intentionné, mais il

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61 7 juin 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/19eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

62 7 juin 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/19eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

a été formé pour croire que, jusqu'à un certain point, ce genre de comportement tient uniquement à la manipulation[63].

Bien que les femmes ne forment qu'un petit groupe, estimé à environ 400 dans l'ensemble de la population carcérale fédérale, elles ont des besoins de santé mentale particuliers. Howard Sapers a parlé d'une étude qui comparait les admissions dans les établissements fédéraux en 1967 et en 2004 et qui faisait ressortir une augmentation de 65 p. cent dans le nombre des délinquantes présentant des problèmes de santé mentale, chiffre qu'il faut réviser à la hausse si on tient compte des cas de consommation abusive. Il a aussi déclaré :

> *Service correctionnel Canada reconnaît que les femmes des établissements fédéraux connaissent un taux d'automutilation et de tentative de suicide supérieur à celui de leurs homologues masculins. La direction de la recherche de SCC a conclu que plus des deux tiers des détenues en sécurité maximale avaient fait une tentative de suicide antérieure, comparé à 21 p. cent des hommes en sécurité maximale. Le taux est donc trois fois supérieur*[64].

Kim Pate a soutenu que les femmes avaient été particulièrement touchées par la désinstitutionnalisation de même que par les coupures dans les programmes sociaux, ce qui donne à croire que pour certaines femmes, la prison est devenue une sorte de système de soins de remplacement :

D'importantes économies pourraient être réalisées si on intervenait auprès des enfants autochtones avant qu'ils ne commencent à avoir des démêlés avec la justice.

> *À cause des coupures occasionnées par la suppression du régime d'Assistance Canada [...], nous avons assisté à une augmentation du nombre de personnes qui sont oubliées par les services de santé mentale, les services sociaux et les services d'éducation et qui aboutissent donc dans le système de justice criminelle. Cela tient au fait qu'il s'agit du seul système qui ne peut fermer ses portes en disant « Non, nous sommes complets, nous n'avons plus de lit » et qu'il n'est pas difficile d'associer un comportement souvent symptomatique d'une maladie mentale à un comportement criminel*[65].

Quelques témoins ont aussi parlé de la surreprésentation des Autochtones dans le système de justice pénale. Michael Bettman a mentionné l'existence de programmes spéciaux, créés par des Autochtones pour le bénéfice des délinquants autochtones et souvent directement offerts par du personnel autochtone. Il signale que :

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63 16 février 2005, [modifié par le traducteur] http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/06eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

64 7 juin 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/19eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

65 16 février 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/06eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

[...] la population autochtone représente 3 p. cent de l'ensemble de la population, mais 17 p. cent de notre population délinquante. Dans la région des Prairies, ce pourcentage frise les 65 p. cent[66].

Darrell Downton, coprésident, Comité consultatif sur la santé mentale et les toxicomanies, Five Hills Regional Health Authority, a mis l'accent sur la prévention. Il estime que d'importantes économies pourraient être réalisées si on intervenait auprès des enfants autochtones avant qu'ils ne commencent à avoir des démêlés avec la justice :

Il peut exister des programmes pour venir en aide aux délinquants, mais il est beaucoup plus important d'intervenir avant que les enfants se mettent à commettre des infractions. C'est une économie de 50 000 $ par année sans compter tous les autres avantages pour la société[67].

13.2.3.5 Toxicomanie

Selon Michael Bettman, près de 80 p. cent des délinquants fédéraux ont un problème de toxicomanie qui conduit à la récidive. Il affirme que le programme mis en œuvre par le Canada est reconnu mondialement et que divers pays européens s'en inspirent :

Le manque de continuité entre le milieu institutionnel et les programmes communautaires entraîne toutes sortes de problèmes aux délinquants, une fois remis en liberté.

Nous avons un programme de réduction de la toxicomanie dans nos établissements à sécurité minimale, moyenne et maximale qui comprend le suivi. Ce sont des programmes centrés sur la réduction du préjudice visant à réduire et à prévenir la toxicomanie. On assure ensuite le suivi pendant toute la peine que purge le délinquant autant au sein de l'établissement que dans la collectivité, après sa libération[68].

Howard Sapers recommande que le SCC mette en œuvre un certain nombre de mesures pour améliorer la situation des délinquants qui ont des problèmes de toxicomanie.

[...] un programme d'échange de seringues en milieu carcéral pour contrer les risques pour la santé publique associés au taux croissant d'infection à l'hépatite C et au VIH. Plusieurs pays européens ont déjà mis en place de tels programmes d'échange de seringues. Ils sont efficaces, en ce sens que les taux d'infection y sont en baisse et que le taux des détenus en bonne santé à la libération est en hausse. On ne signale

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66 23 février 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/08ev-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

67 2 juin 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/17eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

68 23 février 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/08ev-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

aucune augmentation des cas d'abus de drogue dans les prisons, ou de l'emploi de seringues pour des agressions[69].

Michael Flaxman, un bénévole du *From the Heart Committee* de Toronto, a demandé que les délinquants qui ont commis des crimes sans violence liés à la drogue soient tenus à l'écart des autres et aient accès à des programmes principalement axés sur la toxicomanie :

> *[...] pourquoi ne pas avoir un établissement à sécurité minimale-moyenne qui offre des programmes pour les détenus ayant commis des crimes non violents liés à la drogue, selon un continuum précis qui réponde aux besoins des toxicomanes. Ces personnes ont tendance à purger des peines plus courtes que les autres, et avec la procédure d'examen expéditif pour la libération conditionnelle, qui leur permet d'être admissibles à une semi-liberté après avoir purgé le sixième de leur peine, elles pourraient se concentrer sur leur toxicomanie*[70].

Le manque de continuité entre le milieu institutionnel et les programmes communautaires entraîne toutes sortes de problèmes aux délinquants, une fois remis en liberté. Selon Ron Fitzpatrick, directeur exécutif, *Turnings*, lorsqu'un détenu qui recevait un traitement d'entretien à la méthadone est mis en liberté, il devrait être immédiatement intégré à un programme équivalent offert en milieu communautaire, mais souvent ce n'est pas le cas :

> *S'il recevait un traitement d'entretien à la méthadone en prison, il doit continuer de le recevoir à l'extérieur parce qu'il l'a reçu en prison pendant cinq ans. S'il n'est pas immédiatement intégré à un programme, à cause des listes d'attente, sa seule option sera de trouver de la drogue dans la rue et là, il finira par retourner en prison. Et s'il est envoyé dans une prison provinciale pour avoir volé de la drogue, rien ne garantit qu'il sera intégré dans un programme d'entretien à la méthadone*[71].

13.2.4 Commentaire du Comité

En ce qui concerne les délinquants sous responsabilité fédérale — et par extension, toute la population carcérale sous responsabilité provinciale —, le Comité vise un objectif principal, soit un relèvement des normes qui régissent les soins de santé mentale offerts dans les établissements correctionnels (et le milieu des libérations conditionnelles) afin qu'elles soient équivalentes à celles qui s'appliquent aux services offerts à la population

Pour répondre aux besoins des détenus souffrant de maladie mentale ou de toxicomanie, il faut une transformation en profondeur des programmes, des modes de financement et de l'attitude de SCC.

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69 7 juin 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/19eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

70 15 février 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/05evb-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

71 14 juin 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/22eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

générale. Ne pas atteindre cet objectif reviendrait à condamner un trop grand nombre de personnes au syndrome de la porte tournante, c'est-à-dire à un retour perpétuel en prison. Si le but de l'incarcération est à la fois la réadaptation et la protection de la sécurité publique, cet objectif doit absolument être atteint. Sinon, il faudra en conclure que Service correctionnel Canada accorde une priorité plus haute à l'enfermement qu'à la réadaptation.

Le Comité comprend que pour répondre aux besoins des détenus souffrant de maladie mentale ou de toxicomanie, il faut une transformation en profondeur des programmes, des modes de financement et de l'attitude de SCC. D'entrée de jeu, il faut procéder à une évaluation complète de la santé mentale du délinquant à son arrivée au pénitencier fédéral. Il faut des budgets pour financer les programmes et services nécessaires aux besoins de santé mentale de la population carcérale. Il faut que SCC prouve par des gestes concrets sa volonté de mettre la priorité sur la réadaptation et non sur la seule protection du public par l'enfermement. Le Comité reconnaît aussi la nécessité de recueillir et d'analyser des données, et d'approfondir la recherche dans le domaine de la santé mentale. Bref, le Comité presse Service correctionnel Canada d'accorder plus d'importance aux besoins de santé mentale et de toxicomanie des détenus – de consacrer à ces besoins autant d'attention qu'aux besoins de sécurité et d'évaluation du risque — et de faire en sorte que traitement et réadaptation soient harmonieusement coordonnés.

Pour en arriver à des normes équivalentes de soins de santé mentale pour les délinquants fédéraux en milieu carcéral et en milieu de transition après la remise en liberté, le Comité recommande :

72	**Que Service correctionnel Canada (SCC) élabore et mette en œuvre un ensemble de normes en soins de santé mentale applicable dans les établissements carcéraux et en milieu de transition, qui soit équivalent aux normes en vigueur dans les milieux accessibles à la population générale.** **Que les normes de SCC soient fondées sur des données statistiques portant sur les délinquants sous responsabilité fédérale, leurs problèmes de santé mentale et de toxicomanie, notamment la prévalence de la maladie mentale, les traitements utilisés (psychothérapie, médication, etc.), les taux d'hospitalisation, etc.** **Que la mise en œuvre par SCC de cet ensemble de normes fasse l'objet d'un examen annuel confié à un organisme indépendant ayant des compétences dans le domaine de la santé mentale, comme la Commission canadienne de la santé mentale (voir le Chapitre 16).** **Que les données servant de toile de fond aux normes soient rendues publiques et mises à la disposition des chercheurs à des fins d'analyse indépendante.** **Que l'évaluation de rendement soit déposée au Parlement tous les ans à compter de 2008.**

En ce qui concerne les délinquants qui ont besoin de soins et de traitements de santé mentale pendant leur incarcération dans les établissements correctionnels ordinaires, le Comité estime que le personnel devrait recevoir une formation lui permettant de faire la distinction entre une crise de santé mentale et un problème de sécurité. Les délinquants doivent recevoir les services de psychothérapie ou les autres formes de thérapie dont ils ont besoin, de la part de professionnels formés spécifiquement dans le traitement de la maladie mentale.

Le Comité presse Service correctionnel Canada d'accorder plus d'importance aux besoins de santé mentale et de toxicomanie des détenus – de consacrer à ces besoins autant d'attention qu'aux besoins de sécurité et d'évaluation du risque — et de faire en sorte que traitement et réadaptation soient harmonieusement coordonnés.

En ce qui concerne les délinquants sous responsabilité fédérale — et par extension, toute la population carcérale sous responsabilité provinciale —, le Comité vise un objectif principal, soit un relèvement des normes qui régissent les soins de santé mentale offerts dans les établissements correctionnels (et le milieu des libérations conditionnelles) afin qu'elles soient équivalentes à celles qui s'appliquent aux services offerts à la population générale. Si le but de l'incarcération est à la fois la réadaptation et la protection de la sécurité publique, cet objectif doit absolument être atteint.

Le Comité demande instamment qu'une évaluation complète de la santé mentale des délinquants soit faite, par un professionnel dûment formé, à leur arrivée à l'unité de réception, et qu'elle soit faite plus rapidement qu'à l'heure actuelle. Il appuie les efforts de réduction de préjudice et de traitement visant les délinquants toxicomanes. Au delà du programme d'entretien à la méthadone, le Comité est favorable à une évaluation complète des arguments pour et contre la création d'un programme d'échange de seringues dans les établissements fédéraux.

Le Comité recommande :

73	**Que Service correctionnel Canada fasse réaliser, par un professionnel reconnu, une évaluation clinique complète de la santé mentale de chaque délinquant, au plus tard dans les sept jours civils suivant son arrivée à l'unité de réception, afin de déterminer ses besoins en matière de soins de santé mentale ou de toxicomanie.** **Que Service correctionnel Canada donne aux agents correctionnels et autres membres du personnel, dès leur entrée en fonction, une formation leur permettant de faire la distinction entre une crise de santé mentale et un problème de sécurité.** **Que Service correctionnel Canada mette des services de psychothérapie à la portée des délinquants qui en ont médicalement besoin, et que ces services soient offerts par un psychiatre, un psychologue, un travailleur social ou un autre professionnel de la santé n'ayant pas la responsabilité d'évaluer le risque posé par le délinquant.**

Que Service correctionnel Canada augmente la capacité de ses centres de traitement en y ajoutant des lits et du personnel.

Que Service correctionnel Canada mette immédiatement en œuvre dans tous les établissements correctionnels fédéraux des mesures de réduction du préjudice.

Après la remise en liberté des délinquants, le Comité veut des assurances à l'effet que Service correctionnel Canada se porte garant de la continuité des soins, notamment de l'accès aux médicaments au-delà de la provision pour deux semaines donnée à la libération.

Le Comité recommande :

74 **Que Service correctionnel Canada mette sur pied un système de prise en charge qui garantisse aux délinquants l'accès aux traitements de santé mentale dont ils ont besoin après leur mise en liberté, notamment l'accès, sans frais, aux médicaments nécessaires jusqu'à ce qu'ils bénéficient des services communautaires provinciaux ou territoriaux.**

13. 3 LES FORCES ARMÉES CANADIENNES

> *[E]nviron la moitié des gens qui ont des problèmes ne viennent pas demander de l'aide. Nous continuons donc à travailler là-dessus. Y a-t-il de la stigmatisation? Moins qu'avant, mais je crains qu'on ne soit en train de créer deux catégories de maladies mentales. Peut-être est-il acceptable de souffrir de traumatisme lié au stress opérationnel ou de SSPT [syndrome de stress post-traumatique], mais il n'est pas acceptable de souffrir de dépression ordinaire dans l'armée. — Brigadier-général Hilary F. Jaeger, conseillère médicale, Défense nationale* [72]

13.3.1 La compétence fédérale

En vertu du paragraphe 91(7) de l'*Acte de l'Amérique du Nord britannique,1867,* la responsabilité complète des questions militaires, y compris des soins de santé aux militaires, est confiée au gouvernement fédéral. La *Loi canadienne sur la santé* de 1984 exclut nommément les « membres des Forces armées canadiennes » de la catégorie des « assurés ». Ils ne sont pas non plus couverts par les régimes provinciaux d'assurance-maladie ni par le Régime de soins de santé de la fonction publique.

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[72] 23 février 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/08ev-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

En vertu de la *Loi sur la défense nationale,* le ministre de la Défense nationale a le pouvoir de gérer et de diriger les Forces armées canadiennes[73]. Comme l'a expliqué le brigadier-général Hilary F. Jaeger, conseillère médicale, Défense nationale:

> *[L]e gouvernement fédéral a la responsabilité de tous les aspects des soins de santé des membres de la force régulière, de leur recrutement à leur retraite, et aussi pour les réservistes qui y ont droit. Cela comprend aussi les soins de santé mentale*[74].

Selon le Rapport sur le rendement du Ministère pour la période se terminant le 31 mars 2005, la force régulière s'établissait à 61 715 membres en 2004-2005[75]. L'effectif de la Première réserve s'élevait en 2004-2005 à 25 633 membres[76].

Par comparaison avec la population civile, Hilary Jaeger affirme que « la prévalence de la dépression dans l'année précédant l'enquête était plus élevée de 80 p. cent que celle de la population en général

Pour déterminer la prévalence de la maladie mentale parmi les membres de la force régulière et des forces de réserve, la Défense nationale et Statistique Canada ont fait établir en 2002 un Supplément Forces armées canadiennes à l'Enquête sur la santé dans les collectivités canadiennes. Il devient ainsi possible de comparer la population civile et la population militaire du point de vue de la prévalence de certaines maladies mentales, de l'impression de bien-être psychologique et de l'utilisation des services[77].

Si le syndrome de stress post-traumatique est la forme de maladie mentale la plus souvent associée aux Forces armées canadiennes, il ne figure pas parmi les trois troubles les plus prévalents

Le brigadier-général Jaeger indique que les membres de la force régulière ont une incidence annuelle de problèmes de santé mentale d'environ 15 p. cent contre 13 p. cent dans les forces de réserve, et que la prévalence à vie s'établit à 30 et 35 p. cent[78]. Par comparaison avec la population civile, Hilary Jaeger affirme que « la prévalence de la dépression dans

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73 *Loi sur la défense nationale*, L.R.C. 1985, c. N-5, http://lois.justice.gc.ca/fr/N-5/.

74 23 février 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/08ev-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

75 Défense nationale, *Rapport sur le rendement pour la période se terminant le 31 mars 2005*, http://www.tbs-sct.gc.ca/rma/dpr1/04-05/ND-DN/ND-DNd45_f.asp.

76 *Ibid.*, p. 88; la Première réserve se compose de la Réserve navale, la Réserve de l'Armée de terre, la Réserve aérienne, la Réserve des communications, la Réserve des services de santé, la Réserve des services juridiques, et le cadre de la Première réserve du Quartier général de la Défense nationale.

77 Défense nationale, *L'Enquête de Statistique Canada sur la santé mentale dans les FC : une « étape clé »* http://www.forces.gc.ca/health/information/op_health/stats_can/engraph/MH_Survey_f.asp.

78 Une lettre du brigadier-général Hilary F. Jaeger, conseillère médicale, Défense nationale, au sénateur Michael Kirby, président, Comité sénatorial permanent des affaires sociales, des sciences et de la technologie, le Sénat, 2 février 2006 précisait que l'enquête n'ayant pas mesuré toutes les formes de maladie mentale, la prévalence à vie réelle était sans doute plus élevée.

l'année précédant l'enquête était plus élevée de 80 p. cent que celle de la population en général »[79].

Le brigadier-général Jaeger a aussi dit au Comité que même si le syndrome de stress post-traumatique est la forme de maladie mentale la plus souvent associée aux Forces armées canadiennes, il ne figure pas parmi les trois troubles les plus prévalents :

> *La principale cause de souffrance psychologique, c'est la dépression, qui atteignait 7,6 p. cent pour l'année précédant l'enquête. La consommation excessive d'alcool ou la dépendance de type alcoolique atteignait 4 p. cent, et la phobie sociale 3,6 p. cent. Le SSPT représentait 2,8 p. cent et le trouble panique 2,2 p. cent — tous ces chiffres se rapportent à la force régulière qui, en général, a une incidence plus élevée de maladies mentales que la réserve*[80].

13.3.2 Programmes et services fédéraux

Le brigadier-général Jaeger a déclaré que les Forces canadiennes ont entrepris de renouveler en profondeur leur façon d'aborder les soins de santé mentale et ont commencé à mettre en œuvre un modèle de prestation de soins qui tient compte de facteurs multiples :

> *Nous croyons à un point de vue très holistique en matière de santé mentale. Nous estimons qu'il s'agit de l'élément de la santé qui se rapporte aux questions cognitives, émotionnelles, organisationnelles et spirituelles, et que la santé mentale est bien plus que l'absence de maladie psychiatrique. Nos normes sont donc assez élevées*[81].

En novembre 2005, le Bureau du médecin-chef des FC a publié une « documentation » faisant le point sur les Programmes de santé mentale des Forces canadiennes[82]. L'information porte sur la prestation des services de santé, la protection de la santé, le soutien aux blessés, le soutien aux familles, et l'initiative Rx2000 sur la santé mentale (nom du projet de réforme et restructuration des services de santé des Forces canadiennes) et les partenariats avec Anciens Combattants Canada.

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79 23 février 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/08ev-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

80 23 février 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/08ev-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

81 23 février 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/08ev-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

82 Défense nationale, Salle de presse - documentation, « Compte rendu — Programmes de santé mentale des Forces canadiennes » BG 05.037, 10 novembre 2005, http://www.dnd.ca/site/newsroom/view_news_f.asp?id=1804.

13.3.2.1 Services généraux de santé mentale

On s'adresse aux provinces pour les services spécialisés

Le ministère de la Défense nationale procure aux membres des Forces canadiennes des soins de santé non urgents en consultation externe dans les cliniques, centres médicaux et unités de soutien des sites militaires répartis sur le territoire canadien. Ces unités médicales traitent les maladies qui ne mettent pas la vie en danger, font des interventions chirurgicales mineures, offrent des consultations en cas de problèmes mineurs de santé mentale, et distribuent des médicaments en fonction des besoins[83].

Après les heures normales, en cas d'urgence ou en région éloignée, les membres des FC s'adressent aux hôpitaux et autres services de santé civils. Certaines grandes cliniques militaires offrent des soins de santé mentale spécialisés, mais en règle générale, on s'adresse aux provinces pour ces services spécialisés.

La Réforme des services de santé des Forces canadiennes (Rx2000) est un vaste projet de restructuration médicale qui comprend un volet santé mentale. Des crédits de 98 millions de dollars sur six ans ont récemment été engagés pour améliorer la prestation des services de santé des FC au moyen d'un certain nombre de mesures :

- accroître le nombre des fournisseurs de soins de santé mentale à la disposition des membres des FC partout au pays;
- normaliser les méthodes d'évaluation et de traitement de certains problèmes de santé et s'assurer que le personnel accepte bien les nouvelles approches thérapeutiques;
- perfectionner le dépistage psychosocial préalable aux déploiements pour favoriser une intervention précoce;
- améliorer les services externes d'éducation;
- faire de la recherche pour améliorer les pratiques et mesurer les résultats.

13.3.2.2 Soutien en cas de stress opérationnel

Les membres des Forces canadiennes sont soumis à des facteurs de stress particuliers lorsqu'ils participent à des missions de combat, de résolution de conflits ou de maintien de la paix. Les devoirs qu'ils accomplissent dans le cadre de la vie militaire peuvent devenir des expériences fortement traumatisantes : pertes importantes, attaques armées, prises d'otages, massacres, décès de collègues et de civils, etc.

En 1999, le Ministère a ouvert cinq Centres de soutien pour trauma et stress opérationnels aux bases de Halifax, de Valcartier, d'Ottawa, d'Edmonton et d'Esquimault. On y traite les problèmes psychologiques, émotionnels, spirituels et sociaux qui résultent des opérations militaires.

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[83] Défense nationale. *Le système de santé des militaires*. « Services de santé en garnison » http://www.forces.gc.ca/health/about_us/engraph/in_garrison_f.asp.

En 2002, le MDN et Anciens Combattants Canada ont lancé conjointement le Projet de soutien social aux victimes de stress opérationnel (SSVSO), un réseau d'entraide pancanadien conçu pour aider les membres et anciens membres des FC qui souffrent de traumatisme lié au stress opérationnel (TSO).

On définit ainsi le traumatisme lié au stress opérationnel (TSO) : toute difficulté psychologique persistante attribuable aux fonctions exécutées par un membre des Forces canadiennes dans le cadre d'une opération, notamment le syndrome de stress post-traumatique (SSPT) [84]. En 2003, les résultats préliminaires d'un programme amélioré de dépistage médical post-déploiement destiné aux membres des Forces canadiennes déployés en Afghanistan et en Asie du Sud-Ouest ont révélé un « niveau perturbant de détérioration du bien-être physique et mental »[85]. Mais sur une note plus positive, le processus a permis de repérer plusieurs militaires présentant des problèmes et de les orienter vers le traitement approprié.

13.3.2.3 Stress et toxicomanie

Lorsque le travail oblige les membres des FC à se séparer de leur famille, tant la séparation que les retrouvailles peuvent être source d'émotions fortes et de stress. En 2000, la Direction de la politique médicale du MDN a publié une série de brochures portant sur le stress entourant notamment le déploiement, les retrouvailles et les incidents critiques [86].

Les politiques du Ministère en matière d'alcool et de drogues proposent des moyens d'intervention efficaces[87]. Les surveillants sont invités à reconnaître les signes avant-coureurs de problèmes liés à la consommation d'alcool ou au jeu excessif et à intervenir rapidement pour prévenir de plus graves problèmes de santé et de sécurité. Dans un premier temps, on suggère des séances d'éducation et la participation de professionnels de la santé, tandis qu'une consultation ou un programme de traitement pour toxicomanie peuvent être prescrits par un médecin.

Le Ministère offre aussi des programmes de promotion de la santé mentale et de prévention de certains comportements négatifs liés au stress, comme la toxicomanie, la violence familiale et le suicide. L'approche interdisciplinaire de ces programmes fait intervenir des

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84 Soutien social Blessure Stress opérationnel, *Information pour les militaires, actifs et retraités*, « Les traumatismes liés au stress opérationnel » http://www.osiss.ca/sitePage.txp?ud_siteSectionId=14347&tx_target=main1131814980596.

85 Mark Zamorski, *Évaluation d'un programme amélioré de dépistage médical post-déploiement destinés aux militaires canadiens déployés dans le cadre de l'opération Apollo (Afghanistan/Asie du Sud-Ouest) : Résultats préliminaires et plan d'action, juin* 2003, http://www.forces.ca/health/information/op_health/op_apollo/engraph/op_apollo_toc_f.asp.

86 Défense nationale, Direction de la politique médicale, série de brochures intitulées *Se préparer au stress provoqué par un incident critique, Un déploiement moins stressant, Des retrouvailles moins stressantes,* 2000 http://www.forces.gc.ca/health/information/engraph/health_promotion_home_f.asp?Lev1=2&Lev2=5.

87 Défense nationale, *Aide Mémoire sur le rôle du surveillant en ce qui concerne l'abus d'alcool*, SCEM Protection de la santé des Forces, 2004, http://www.forces.gc.ca/Health/Services/health_promotion/PDF/Aide%20Memoire%20for%20the%20Supervisor%27s%20Role%20in%20Dealing%20with%20Alcohol%20Misuse.pdf.

psychiatres, des psychologues cliniciens, des infirmières en santé mentale, des travailleurs sociaux, des intervenants en toxicomanie et des aumôniers, et tous partagent la responsabilité avec les fournisseurs de soins primaires.

13.3.2.4 Congés et libérations pour cause médicale

D'après le brigadier général Jaeger, environ 42 p. cent des congés de maladie que prennent les militaires sont liés à la santé mentale, et environ 23 p. cent des militaires qui sont réformés pour cause de maladie présentent comme diagnostic principal une maladie mentale[88]. Elle indique que le Ministère parvient peut-être mieux que la plupart des employeurs à adapter les conditions de travail du personnel, ce qui réduit le nombre de militaires réformés pour cause de maladie :

> *Nous pouvons organiser du travail à mi-temps, réaffecter une personne à un travail moins stressant, ou à un travail moins exigeant physiquement*[89].

Néanmoins, le colonel D. R. Boddam, principal gestionnaire des Forces canadiennes en matière de psychiatrie et de santé mentale, Défense nationale, a informé le Comité que s'il est vrai que la majorité des personnes qui reçoivent un diagnostic de maladie mentale reviennent au travail après leur traitement, il reste qu'environ 300 personnes par année sont réformées pour cause de maladie mentale. Il a ajouté que la Défense nationale vient de mettre sur pied un projet de travail conjoint avec Anciens Combattants Canada:

> *Pour ceux qui ont subi un préjudice psychologique par suite de leur emploi, nous voulons travailler ensemble pour être capables de fournir cette continuité des traitements, à partir du moment où ils commencent à recevoir des soins jusqu'à celui où ils retournent à la vie civile*[90].

Le brigadier-général Jaeger a insisté sur le fait que ces libérations et restrictions d'emploi pour cause de maladie sont un sujet de vive préoccupation tant pour le Ministère que pour les militaires en cause :

Environ 42 p. cent des congés de maladie que prennent les militaires sont liés à la santé mentale.

> *Environ 2 300 de nos membres font l'objet d'un examen visant à déterminer leur capacité de demeurer au service des Forces canadiennes. Environ 23 p. cent de ces dossiers, chaque année, sont attribuables à la maladie mentale et ce n'est peut-être pas étonnant. Ces*

La majorité des personnes qui reçoivent un diagnostic de maladie mentale reviennent au travail après leur traitement, il reste qu'environ 300 personnes par année sont réformées pour cause de maladie mentale.

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88 Lettre du brigadier-général Hilary F. Jaeger, conseillère médicale, Défense nationale, au sénateur Michael Kirby, président, Comité sénatorial permanent des affaires sociales, des sciences et de la technologie, le Sénat, 2 février 2006.

89 23 février 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/08ev-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

90 23 février 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/08ev-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

personnes sont beaucoup plus exposées que les autres à une libération des Forces canadiennes [91].

13.3.3 Évaluation des besoins du groupe client

13.3.3.1 Soins généraux de santé mentale

Le brigadier-général Jaeger reconnaît la difficulté que présentera la mise sur pied d'équipes de santé mentale pour répondre aux besoins des membres des FC. Elle a indiqué que le Ministère va devoir doubler son personnel et qu'il sera sans doute difficile de trouver des gens compétents pour combler les postes car il faudra « recruter des professionnels dans le secteur civil, et nous savons qu'il y a une pénurie générale de professionnels de la santé »[92].

Le colonel Boddam a indiqué que la nécessité de compter sur le système civil de soins de santé pour traiter les militaires plus gravement atteints est aussi une source de préoccupation pour les membres des FC qui ont une maladie mentale plus grave :

La nécessité de compter sur le système civil de soins de santé pour traiter les militaires plus gravement atteints est aussi une source de préoccupation pour les membres des FC qui ont une maladie mentale plus grave.

> *Le nombre de lits disponibles dans les ailes psychiatriques est limité. Nous ne disposons pas de telles installations, et nous ne pouvons pas toujours y accéder rapidement. Cela nous préoccupe tout particulièrement car de par la nature de leur carrière, les militaires se déplacent fréquemment de sorte que les réseaux d'appui que constituent la famille éloignée et les amis de longue date sont moins susceptibles de venir en aide à un militaire en détresse psychologique*[93].

Un certain nombre des efforts conjoints de la Défense nationale et d'Anciens Combattants Canada visent les militaires encore actifs et ceux qui sont en transition vers la vie civile. Le brigadier-général Jaegar s'est montrée optimiste devant le partenariat et la convergence des objectifs dans le secteur des services de santé mentale :

> *Il s'agit de donner aux membres des Forces canadiennes l'accès aux ressources de ACC quand c'est logique, et vice versa. À plus ou moins longue échéance, nous souhaitons [intégrer les effectifs de] ces services*[94].

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91 23 février 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/08ev-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

92 23 février 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/08ev-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

93 23 février 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/08ev-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

94 23 février 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/08ev-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

13.3.3.2 Résultats des interventions en santé mentale

Sur la question de savoir si l'aveu d'une maladie mentale risque de provoquer la fin d'une carrière militaire au lieu d'un retour au travail après une période de traitement, le brigadier-général Jaeger a déclaré que :

> *La vaste majorité des gens qui souffrent de troubles mentaux reçoivent un traitement approprié et réintègrent leurs fonctions. Personne ne s'en aperçoit. Nous aimerions bien que quelqu'un se lève et affirme : « Cela m'est arrivé. » Il y a le général Dallaire qui est un porte-parole éloquent pour ceux qui souffrent de traumatisme lié au stress opérationnel, mais il a dû prendre sa retraite des forces armées. Toutefois, nous aimerions bien compter sur quelqu'un qui exemplifie l'envers de la médaille. Pour des raisons de confidentialité, on ne peut forcer personne à le faire. On ne peut que demander des volontaires*[95].

Il a aussi été question de l'accès à la pension et du niveau des prestations, dans le cas des personnes réformées pour cause médicale.

Il a aussi été question de l'accès à la pension et du niveau des prestations, dans le cas des personnes réformées pour cause médicale. Le brigadier-général Jaeger a signalé les critères d'admissibilité très stricts du Régime d'assurance-revenu militaire (RARM)[96]. Ce régime collectif d'assurance offre des prestations d'invalidité de longue durée aux militaires blessés, invalides ou réformés pour cause médicale :

> *Pour ce qui est du droit à la pension, si vous êtes libéré des Forces canadiennes pour raisons médicales après 10 ans de service, vous avez droit immédiatement à une rente suivant le nombre d'années de service, à savoir 2 p. cent pour chaque année de service. Si vous êtes libéré après 16 ans de service, votre pension est de 32 p. cent indexée au taux d'inflation. Vous avez droit au régime d'assurance-revenu militaire, le RARM, qui bonifie cela à hauteur de 75 p. cent de votre salaire, mais il faut satisfaire à un certain critère, à savoir l'incapacité générale. C'est assez exigeant.*
>
> *Si l'on arrive à démontrer au ministère des Anciens Combattants que l'incapacité est attribuable au service militaire ou a été aggravée par le service militaire, les administrateurs accueillent favorablement une telle*

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95 23 février 2005. http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/08ev-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

96 Académie canadienne de la défense, *En avant — Manuel à l'intention des militaires qui se préparent à quitter les Forces canadiennes*, « chapitre 8 — Pension et prestations d'invalidité », 2002, http://www.cda-acd.forces.gc.ca/er/frgraph/mss/handbook/handbook_f.asp.

requête et l'intéressé devient admissible à une pension correspondant au pourcentage de son incapacité[97].

13.3.3.3 Recours en cas de problèmes de santé mentale

Depuis quelques années, deux possibilités s'offrent aux membres des FC qui ont des griefs à formuler pour cause de problèmes de santé mentale ou autres problèmes résultant de leur travail. En 1998, le Ministre a créé un poste d'Ombudsman chargé de faire enquête sur les plaintes et d'agir à titre de tierce partie neutre dans diverses affaires mettant en cause des militaires et des employés civils de la Défense nationale et des Forces canadiennes. En 2000, on a créé le Comité des griefs des Forces canadiennes, un tribunal civil indépendant, habilité à entendre des griefs liés à divers aspects de la vie militaire et notamment au droit à des soins médicaux.

Très récemment, soit en 2004, l'Ombudsman a mené une enquête de suivi sur la question du stress opérationnel [98]. Il s'est réjoui de la qualité des soins dispensés par les Cliniques de soutien aux victimes de stress opérationnel; des sommes accrues consacrées au traitement du stress opérationnel; du succès que remporte le groupe de Soutien social aux victimes de stress opérationnel, lequel a offert soutien et entraide à plus de 1 000 membres des FC. Le rapport de l'Ombudsman note tout de même qu'il y a encore des choses à améliorer, notamment :

> *[...] la formation et l'éducation pour changer les attitudes à l'égard des traumatismes liés au stress opérationnel; les communications entre la chaîne de commandement opérationnelle et les personnes qui traitent les membres des FC qui souffrent de traumatismes liés au stress opérationnel; ainsi que la coordination de la formation, de l'information et des initiatives relatives aux TSO dans l'ensemble des FC*[99].

En 2004-2005, le Bureau de l'Ombudsman de la Défense nationale a reçu un grand nombre de plaintes portant sur la libération des forces armées (218), des problèmes médicaux (97) et des traumatismes liés au stress opérationnel (35). Le Comité des griefs des Forces canadiennes ne fait pas état des dossiers qu'il traite se rapportant à des problèmes de santé[100].

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97 23 février 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/08ev-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

98 Bureau de l'Ombudsman de la Défense nationale, *Rapport annuel 2004-2005*, juin 2005, http://www.ombudsman.forces.gc.ca/reports/annual/2004-2005_f.asp.

99 *Ibid.*, section intitulée « Suivi du traitement par les FC des traumatismes liés au stress opérationnel ».

100 Comité des griefs des Forces canadiennes, voir le sommaire des causes dans l'index, une recherche n'a pas fait apparaître le SSPT; un cas de toxicomanie a toutefois été trouvé; http://www.cfgb-cgfc.gc.ca/index-f.php

13.3.4 Commentaire du Comité

Le Comité se réjouit de constater que le ministère de la Défense nationale offre un aussi large éventail de services aux membres des Forces canadiennes qui ont des problèmes de santé mentale. La prestation de services de soutien familial en plus des services médicaux et du soutien aux blessés est digne d'éloges.

Le Comité se réjouit de constater que le ministère de la Défense nationale offre un aussi large éventail de services aux membres des Forces canadiennes qui ont des problèmes de santé mentale. La prestation de services de soutien familial en plus des services médicaux et du soutien aux blessés est digne d'éloges. Le Comité approuve particulièrement les efforts qui sont faits pour réduire le stress causé aux militaires et à leur famille par les séparations qu'entraînent les déploiements et par les fréquentes relocalisations.

Le Comité comprend que des programmes et services de santé mentale sont relativement nouveaux et dispersés sur l'ensemble des établissements militaires. Ces initiatives devraient faire l'objet d'une évaluation soigneuse et les résultats soumis au Parlement.

Le Comité recommande :

75	**Que le ministère de la Défense nationale fasse le relevé annuel de ses programmes et services de santé mentale.** **Que ce relevé comprenne une description claire de chaque programme ou service comprenant le nombre de clients desservis, les budgets consentis et les sommes dépensées, et une évaluation des résultats obtenus.** **Que ce relevé soit déposé au Parlement tous les ans à compter de 2008.**

Le Comité estime qu'il est encore possible d'améliorer le réseau d'entraide et, à plus longue échéance, de transformer les mentalités afin que les traumatismes liés au stress opérationnel soient repérés plus tôt et les services mis en place en temps opportun.

Le Comité comprend que les militaires canadiens, tant actifs que retraités, sont réticents à parler des expériences traumatisantes qu'ils ont vécues. Le Comité estime que le Ministère a la responsabilité de fournir aux militaires actifs de fréquentes occasions d'aborder la question des traumatismes liés au stress opérationnel. Bien que le soutien social offert aux militaires et à leur famille se soit amélioré, et que l'accès aux programmes et services nécessaires soit accru, le Comité estime qu'il est encore possible d'améliorer le réseau d'entraide et, à plus longue échéance, de transformer les mentalités afin que les traumatismes liés au stress opérationnel soient repérés plus tôt et les services mis en place en temps opportun. Ces traumatismes comprennent non seulement le syndrome de stress post-traumatique, mais aussi l'anxiété, la dépression et diverses autres manifestations de stress comme la consommation d'alcool et de drogue, et la dysfonction familiale.

Le Comité recommande :

76	**Que la Défense nationale exige de tout le personnel médical qu'il reçoive une formation relative aux traumatismes liés au stress opérationnel et que cette formation comprenne notamment :** • **la consignation du détail des antécédents militaires et des circonstances ayant produit le traumatisme;** • **la reconnaissance/détection des symptômes du traumatisme lié au stress opérationnel;** • **la connaissance des diverses modalités de traitement;** • **les méthodes de suivi à long terme.** **Que la Défense nationale mette cette information à la disposition du personnel médical civil, au moyen de publications, de séminaires ou par d'autres tribunes publiques.** **Que la Défense nationale étudie les moyens de promouvoir le recours plus large aux réseaux d'entraide et la mise à contribution accrue de la famille et de la collectivité.**

Le Comité se préoccupe aussi du sort des réservistes qui travaillent pour la Défense nationale mais n'ont pas le même rapport à leur employeur que les militaires de la force régulière. Lorsqu'ils reviennent de mission ou d'exercices de mobilisation, ils n'ont pas nécessairement accès à tout le soutien offert sur une base militaire. Le Comité estime que le Ministère a la responsabilité de veiller à ce que des services de suivi soient également offerts aux réservistes. Il faut prévoir un temps de transition suffisant entre la force régulière et la force de réserve; veiller à ce que les réservistes reçoivent une évaluation médicale adéquate et notamment soient évalués pour traumatisme possible lié au stress opérationnel. Pour le Ministère, cela peut vouloir dire que la période d'emploi du réserviste sera prolongée jusqu'à ce que les évaluations nécessaires aient été faites.

Le Comité recommande :

77	**Que la Défense nationale évalue les programmes et services actuellement offerts aux réservistes en matière de problèmes de santé mentale résultant de leur mobilisation, notamment les services visant le stress post-traumatique et la toxicomanie, et qu'elle fasse rapport au Parlement.**

13.4 LES ANCIENS COMBATTANTS

> *[U]ne bonne santé mentale est capitale pour la réinsertion, et un bon programme de réinsertion est important pour la santé mentale — Brian Ferguson, Sous-ministre adjoint, Direction des services aux anciens combattants, Anciens Combattants Canada*[101]

13.4.1 La compétence fédérale

Contrairement aux membres actifs des Forces canadiennes, les anciens combattants entrent dans la catégorie des « assurés », en vertu de la *Loi canadienne sur la santé*, pour ce qui est des services de santé en général, et notamment les services de santé mentale. Dans la plupart des cas, Anciens Combattants Canada (ACC ou MAC) ne couvre pas les services non assurés par les régimes d'assurance-maladie des provinces ou territoires, bien que les anciens combattants au revenu admissible aient droit à un soutien supplémentaire. Les anciens combattants qui touchent une rente d'invalidité ont droit au remboursement de leurs frais de traitement liés à l'affection ouvrant droit à pension.

Dans la plupart des cas, Anciens Combattants Canada (ACC ou MAC) ne couvre pas les services non assurés par les régimes d'assurance-maladie des provinces ou territoires, bien que les anciens combattants au revenu admissible aient droit à un soutien supplémentaire.

Les principales dispositions législatives qui régissent les anciens combattants et leurs soins de santé se trouvent dans la *Loi sur le ministère des Affaires des anciens combattants* et dans la *Loi sur les pensions* et, depuis 2005, dans la *Loi sur les mesures de réinsertion et d'indemnisation des militaires et vétérans des Forces canadiennes* [102]. En vertu de la *Loi sur le ministère des Affaires des anciens combattants,* le *Règlement sur les soins de santé pour anciens combattants* définit la santé comme un état de bien-être physique, mental et social. Cette Loi établit les critères d'admissibilité à plusieurs prestations, notamment les soins de santé, les adaptations domiciliaires, les coûts de déplacement pour des examens ou des traitements et autres soins de santé communautaires [103].

La *Loi sur les pensions* définit l'invalidité comme « la perte ou l'amoindrissement de la faculté de vouloir et de faire normalement des actes d'ordre physique ou mental ». La *Loi sur les mesures de réinsertion et d'indemnisation des militaires et vétérans des Forces canadiennes* autorise le Ministère à offrir aux membres actifs et retraités des Forces canadiennes du soutien au placement professionnel, au recyclage professionnel et à la réadaptation, et des prestations financières, d'invalidité et de soins de santé.

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101 23 février, 2005 http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/08ev-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

102 *Loi sur le ministère des Affaires des anciens combattants* L.R.C. 1985, ch. V-1, http://lois.justice.gc.ca/fr/V-1/ *Loi sur les pensions*, L.R.C. 1985, ch. P-6 http://lois.justice.gc.ca/fr/P-6/; *Loi sur les mesures de réinsertion et d'indemnisation des militaires et vétérans des Forces canadiennes*, http://lois.justice.gc.ca/fr/C-16.8/index.html.

103 *Règlement sur les soins de santé pour anciens combattants* http://lois.justice.gc.ca/fr/V-1/SOR-90-594/.

Brian Ferguson, sous-ministre adjoint, Direction des services aux anciens combattants, Anciens Combattants Canada, décrit la façon de procéder du Ministère en ce qui a trait aux services de santé mentale :

> *En vertu du Règlement sur les soins de santé pour anciens combattants, si un besoin est lié à une affection ouvrant droit à pension, ACC paiera pour les traitements. Pour les anciens combattants se qualifiant, ACC paiera pour les traitements n'ouvrant pas droit à pension si le service n'est pas assuré par le régime provincial d'assurance-maladie.*
>
> *Exception faite des services fournis à notre hôpital de Sainte-Anne, tous les services de santé qu'ACC fournit à ses clients sont offerts par les autorités provinciales, des organismes non gouvernementaux et des fournisseurs autorisés du secteur privé. Notre réseau de bureaux dans les districts et les régions nous permet de rester en contact avec les gouvernements provinciaux*[104].

En mars 2005, ACC versait des prestations et offrait des services à environ 219 000 clients[105]. La clientèle est formée de militaires et de civils :

- membres des Forces canadiennes et vétérans de la Marine marchande ayant servi pendant la Première Guerre mondiale, la Deuxième Guerre mondiale ou la guerre de Corée;
- civils ayant droit à des prestations pour service en temps de guerre;
- anciens membres des Forces canadiennes (dont ceux des zones de service spécial) et de la Gendarmerie royale du Canada;
- survivants et personnes à charge d'un militaire ou d'un employé civil.

En traitant spécifiquement des pensions d'invalidité et des soins de santé, Brian Ferguson a indiqué que le nombre de clients desservis par le Ministère avait légèrement diminué pour s'établir à environ 209 000 personnes. Mais il a aussi signalé une augmentation sensible des militaires actifs ou retraités des Forces canadiennes desservis par ACC :

> *[...] 18 p. cent [de nos clients] sont des membres actifs ou retraités des Forces canadiennes. Notre clientèle a augmenté de 58 p. cent dans les trois dernières années et nous prévoyons compter plus de 58 000 clients des Forces canadiennes d'ici 2013*[106].

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104 23 février 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/08ev-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

105 Anciens Combattants Canada, *Rapport sur le rendement 2004-2005*, p. 10, http://www.tbs-sct.gc.ca/rma/dpr1/04-05/VAC-ACC/VAC-ACCd45_f.pdf.

106 23 février 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/08ev-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

M. Ferguson a expliqué qu'un sondage mené auprès des membres actifs ou retraités des Forces canadiennes avait révélé que 15 p. cent des répondants faisaient état de symptômes de stress post-traumatique mais n'avaient jamais fait de demande de pension. Malgré ce potentiel de sous-indemnisation, il a déclaré que :

> *Nous versons une pension à plus de 8 000 clients atteints d'affections liées à la santé mentale. Plus de la moitié d'entre eux souffrent du SSPT et chaque année, la maladie fait de plus en plus de victimes chez nos jeunes militaires.*

13.4.2 Programmes et services fédéraux

13.4.2.1 Pension d'invalidité

Le droit à une pension dépend de la nature du service accompli par le demandeur. En cas de participation à une guerre, à une mission de maintien de la paix ou à d'autres formes de service spécial, la blessure ou la maladie doit être directement attribuable aux fonctions exercées par le demandeur. En cas de service en temps de paix ou de service dans la GRC, la blessure ou la maladie doit résulter directement de l'exercice des fonctions. Il en résulte deux types de pensions, comme le décrit le Tribunal des anciens combattants (révision et appel) :

> La première, pour service en situation de guerre, de maintien de la paix ou de service spécial, accorde une protection 24 heures par jour et est donc couramment appelée principe d'assurance. La deuxième, pour service en temps de paix et dans la GRC, est appelée principe d'indemnisation. La protection est alors semblable à celle des programmes d'indemnisation des accidentés du travail[107].

Anciens Combattants Canada administre la *Loi sur les pensions* et par l'intermédiaire du Programme des pensions d'invalidité, verse une pension à ceux qui ont été rendus invalides dans l'exercice de leurs fonctions militaires en temps de guerre ou de paix, de même qu'aux membres admissibles de la GRC. La pension est proportionnelle au degré d'invalidité, certifié par un examen médical, et est déterminée d'après la Table des invalidités[108].

La pension est proportionnelle au degré d'invalidité, certifié par un examen médical, et est déterminée d'après la Table des invalidités. Le programme des pensions d'invalidité est la tête de pont de l'ensemble des programmes et services de soins de santé par Anciens Combattants Canada.

Le programme des pensions d'invalidité est la tête de pont de l'ensemble des programmes et services de soins de santé offerts par Anciens Combattants Canada, programmes initialement conçus pour répondre aux besoins des vétérans de guerre traditionnels plutôt que des membres actifs et retraités actuels des Forces canadiennes.

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107 Tribunal des anciens combattants (révision et appel), *Loi sur les pensions annotée*, 2005, http://www.vrab-tacra.gc.ca/Documents/AnnotatedAct-March2005.pdf.

108 Anciens Combattants Canada, *Rapport sur le rendement 2004-2005*, p. 17, http://www.tbs-sct.gc.ca/rma/dpr1/04-05/VAC-ACC/VAC-ACCd45_f.pdf.

Toutefois, la nouvelle « Charte des vétérans » — la *Loi sur les mesures de réinsertion et d'indemnisation des militaires et vétérans des Forces canadiennes* — a modifié la donne. Ses modalités, dont une première ébauche est parue en décembre 2005, sont beaucoup mieux adaptées aux besoins des membres actuels des Forces canadiennes qui sont réformés pour cause d'invalidité [109]. Elles visent à corriger les lacunes dans les programmes et services offerts aux membres admissibles réformés pour raison médicale et à ceux qui ont quitté volontairement les Forces canadiennes et se sont découvert par la suite une invalidité liée à leur service militaire.

On peut lire dans l'introduction du Règlement :

> [L]a Loi soutiendra l'ensemble des avantages sociaux actuel fourni par le Régime d'assurance-revenu militaire (RARM) et le ACC. La plupart des militaires de FC qui sont libérés volontairement et qui sont ultérieurement atteints d'une invalidité liée au service ne pouvaient, jusqu'à maintenant, qu'être admissibles à une pension du MAC et aux soins de santé connexes. Le RARM continuera d'offrir aux membres des FC libérés pour raisons de santé des indemnités de remplacement de revenu et de réadaptation professionnelle. En vertu de la Loi, le MAC répondra aux besoins du groupe connaissant des lacunes et offrira des avantages supplémentaires au groupe inscrit au RARM, comme une réadaptation professionnelle additionnelle, une réadaptation médicale ou psychosociale, et l'allocation de soutien du revenu[110].

13.4.2.2 Programme de soins de santé

On espère que le nouveau Programme des soins de santé « comblera les lacunes de l'assurance-santé après la libération en veillant à ce que les vétérans des FC libérés aient accès à une assurance-santé de groupe familiale.

À l'heure actuelle, les clients admissibles à des soins ou des services de santé à la charge d'ACC ont une carte d'identification qui leur donne accès à des fournisseurs de soins partout au pays. Anciens Combattants Canada offre un large éventail de services et de soins en vertu des mandats du Programme de prestations de traitement, du Programme de soins de longue durée et du Programme pour l'autonomie des anciens combattants. Ces services comprennent notamment :

- des services communautaires de santé mentale (ce qui englobe une gamme complète de soins non offerts par la province) pour les vétérans de guerre et les retraités des Forces canadiennes qui répondent aux critères de revenu ou qui touchent une pension d'invalidité résultant de leur service militaire;

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109 Gouvernement du Canada, *Gazette du Canada,* « Règlement sur les mesures de réinsertion et d'indemnisation des militaires et vétérans des Forces canadiennes » vol. 139, no 51, 17 décembre 2005, http://canadagazette.gc.ca/partI/2005/20051217/html/regle7-f.html.

110 *Ibid.*, le Régime d'assurance-revenu militaire (RARM) est décrit sous la rubrique précédente 13.3.3.2.

- des soins institutionnels de santé mentale (soins psycho-gériatriques, maladie d'Alzheimer) aux vétérans admissibles, à l'hôpital ministériel de Sainte-Anne-de-Bellevue (Québec), dans des hôpitaux provinciaux dont le Ministère loue des lits, ou à l'hôpital que choisit le client;

- des soins généraux de santé mentale ainsi que des soins pour syndrome de stress post-traumatique et stress opérationnel, dans le cadre de services offerts conjointement par ACC et le MDN.

La *Loi sur les mesures de réinsertion et d'indemnisation des militaires et vétérans des Forces canadiennes* autorise le Ministre à « établir un programme d'assurance collective similaire au Régime de soins de santé de la fonction publique créé par le Conseil du Trésor »[111]. On espère que le nouveau Programme des soins de santé « comblera les lacunes de l'assurance-santé après la libération en veillant à ce que les vétérans des FC libérés pour raisons de santé (avec certaines exceptions pour les réservistes), les vétérans des FC ayant besoin de réadaptation et certains survivants qui sont présentement inadmissibles à l'assurance-santé, aient accès à une assurance-santé de groupe familiale »[112].

13.4.2.3 Efforts conjoints en santé mentale

Certains des programmes et services résultant de la stratégie conjointe d'ACC-MDN en santé mentale annoncés en 2002 comprennent ce qui suit :

- une ligne d'urgence, maintenue conjointement par ACC, MDN et Santé Canada, offrant des services de consultation téléphonique aux anciens combattants et à leur famille, en situation de crise;

- un centre conjoint MDN/ACC à Ottawa pour le soin des militaires blessés et réformés et leur famille, l'accès étant facilité par un numéro sans frais;

- un réseau pancanadien d'agents d'ACC et du MDN consacrés à l'identification précoce des besoins de transition des clients, notamment leurs besoins de prestations d'invalidité;

- un réseau de cliniques de traitement des TSO partout au pays, piloté par le Centre de Sainte-Anne, les autres cliniques étant à London, Winnipeg et Québec[113].

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111 *Loi sur les mesures de réinsertion et d'indemnisation des militaires et vétérans des Forces canadiennes*, 2005, ch.21, http://lois.justice.gc.ca/fr/C-16.8/texte.html.

112 « Un besoin de réadaptation est un problème de santé physique ou mentale attribuable surtout au service dans les Forces canadiennes et constitue une entrave à la réinsertion dans la vie civile. » Gouvernement du Canada, *Gazette du Canada*, « Règlement sur les mesures de réinsertion et d'indemnisation des militaires et vétérans des Forces canadiennes », vol. 139, no 51, 17 décembre 2005, http://canadagazette.gc.ca/partI/2005/20051217/html/regle7-f.html.

113 Le Centre national d'expertise clinique en santé mentale de Sainte-Anne-de-Bellevue a pour mandat de faire progresser les soins cliniques de santé mentale par l'élaboration d'un programme d'expertise clinique, la recherche, l'avancement des connaissances cliniques, la sensibilisation de la population et les

La stratégie en matière de santé mentale comprend aussi la formation continue pour que le personnel reste bien au courant de l'évolution des programmes et services conçus pour mieux s'adapter aux besoins des clients, et la recherche dans le secteur des TSO en partenariat avec le MDN et d'autres. Le projet de règlement qui accompagne la *Loi sur les mesures de réinsertion et d'indemnisation des militaires et vétérans des Forces canadiennes* donne des renseignements sur la prestation des soins par l'intermédiaire de fournisseurs multiples :

> [...] engagera souvent la participation de plusieurs fournisseurs de services de différents organismes, ainsi que des fournisseurs du secteur privé, tandis que le gestionnaire de cas du MAC sera responsable de la coordination de ces services. Par exemple, en cas de problème de santé mentale, l'étape de réadaptation médicale pourrait comporter la participation du médecin, d'un psychiatre en milieu hospitalier, d'une équipe d'intervenants en santé mentale de la collectivité ou d'un thérapeute du secteur privé engagé par le MAC. L'étape psychosociale peut impliquer la participation d'un ergothérapeute ou de spécialistes de la gestion de la douleur tandis que l'étape de réadaptation professionnelle peut comprendre des services d'évaluation spécialisés et la participation de formateurs[114].

Dans le domaine du stress post-traumatique et autres formes de traumatismes liés au stress opérationnel, d'autres travaux sont en cours au sein de la structure militaire et du milieu médical civil. En particulier, ACC appuie activement le Programme de soutien social par les pairs aux victimes de stress opérationnel créé par le MDN :

> *Ce programme d'entraide pancanadien fonctionne grâce à la participation de membres et d'anciens combattants des Forces canadiennes qui ont eux-mêmes souffert de traumatismes liés au stress opérationnel et qui veulent aider leurs collègues à guérir. À l'échelle du pays, le MDN peut actuellement compter sur les services de 13 coordonnateurs de soutien qui, jusqu'à présent, sont venus en aide à plus de 1 400 clients. Ce réseau fait appel à un grand nombre de bénévoles et nous avons des brochures, que nous ferons distribuer aux membres du comité, pour leur montrer certains aspects du travail des bénévoles qui viennent en aide aux coordonnateurs de soutien. — Brian Ferguson*[115]

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activités de rapprochement. Anciens Combattants Canada, *Communiqué de presse,* « Ouverture officielle du Centre national d'expertise clinique en santé mentale » 7 novembre 2005, http://news.gc.ca/cfmx/view/en/index.jsp?articleid=181199&.

[114] Gouvernement du Canada, *Gazette du Canada*, « Règlement sur les mesures de réinsertion et d'indemnisation des militaires et vétérans des Forces canadiennes », vol. 139, no 51, 17 décembre 2005, http://canadagazette.gc.ca/partI/2005/20051217/html/regle7-f.html.

[115] 23 février 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/08ev-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

13.4.3 Évaluation des besoins du groupe client

Les anciens combattants qui ont des problèmes de santé mentale forment un groupe très divers ayant besoin d'un large éventail de services d'aide à la réinsertion : transition assistée; recherche d'emploi; réadaptation; recyclage; soutien du revenu; soins de santé; soutien à la famille; et autres éléments favorisant l'autonomie.

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13.4.3.1 Pension d'invalidité

Selon Brian Ferguson, Anciens Combattants Canada veut mettre au point une seule et même approche pour répondre aux besoins de santé mentale tant des vétérans âgés que des plus jeunes.

Les membres actifs et retraités des FC dont le service militaire s'est déroulé en temps de paix se disent insatisfaits du mode actuel d'accès aux pensions.

> *S'ils ont une maladie ou un état ouvrant droit à pension et ont besoin de traitements, nous payons pour ces traitements, et nous nous tenons au courant des traitements qu'ils reçoivent*[116].

Cependant, les membres actifs et retraités des FC dont le service militaire s'est déroulé en temps de paix, qui forment aujourd'hui, avec les survivants et personnes à charge du personnel militaire, un groupe plus important de bénéficiaires de pensions d'invalidité que les vétérans de guerre, se disent insatisfaits du mode actuel d'accès aux pensions. Une vérification comptable du Programme de pension d'invalidité, réalisée en 2005, a montré que les clients des FC estiment qu'il y a :

L'ironie c'est que les soldats du MDN, en bonne santé (pour la plupart) et aptes au travail, ont accès à un ombudsman indépendant alors que les anciens combattants invalides et inaptes au travail n'en ont pas.

> [...] une compréhension insuffisante de la culture du MDN, y compris de la structure de commandement, et du stress physique, mental et émotionnel de l'entraînement militaire et du déploiement dans des contextes opérationnels outre-mer dangereux[117].

Pour le moment, le Tribunal des anciens combattants (révision et appel) accueille deux niveaux d'appels concernant les demandes de pension d'invalidité et constitue le dernier niveau d'appel des décisions sur les allocations. Pour la période allant d'avril 2004 à mars

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[116] 23 février 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/08ev-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

[117] Anciens Combattants Canada, *Volume II, Évaluation du Programme de pension d'invalidité, juillet* 2005 http://www.vac-acc.gc.ca/general/sub.cfm?source=department/reports/deptaudrep/disapen_eval_july2005.

2005, le Tribunal a entendu 6789 demandes [118]. Les clients et certains autres observateurs signalent des difficultés dans l'évaluation des demandes de prestations pour invalidité psychologique en raison du manque de clarté et d'objectivité des critères et des normes. Ils indiquent que dans le feu de l'action, on estime peu prioritaire de consigner par écrit les détails d'incidents qui ne mettent pas la vie en danger, mais qui peuvent néanmoins avoir des répercussions sur la santé mentale.

En juin 2005, la revue *Esprit de Corps* a publié un communiqué de presse demandant qu'Anciens Combattants Canada crée un poste d'ombudsman, semblable à celui des FC, en précisant que :

> L'ironie c'est que les soldats du MDN, en bonne santé (pour la plupart) et aptes au travail, ont accès à un ombudsman indépendant alors que les anciens combattants invalides et inaptes au travail n'en ont pas.

Le communiqué de presse entrait ensuite dans le détail des complexités des invalidités actuelles et, par conséquent, du faible taux d'attribution de pensions :

> On attribue le plus fréquemment une pension de 20 p. cent ou 400 $/mois pour des invalidités qui ont rendu l'ancien combattant inapte au travail. Par conséquent, la personne, déjà hypothéquée sur le plan physique et(ou) psychologique, doit entreprendre un long et très démoralisant processus de révision et d'appel, qui prendra facilement de trois à cinq ans, avant de recevoir une indemnisation adéquate [119].

13.4.3.2 Gestion de cas

Un responsable de dossier peut aider le client et sa famille à composer avec le déséquilibre psychologique et à s'y retrouver dans le dédale des programmes.

La méthode de gestion de cas adoptée par Anciens Combattants Canada permet au ministère de suivre l'évolution de l'état de chaque client. Le but est de simplifier l'accès aux programmes existants et de fournir un service adéquat de prise en charge, surtout pour ceux qui sont réformés pour raison médicale et qui ont souvent besoin de beaucoup d'aide pour se réinsérer dans la vie civile. On veut que le responsable du dossier aide la personne à s'y retrouver dans le dédale des fournisseurs de services et des prestations offertes par ACC, le MDN, le RARM, le ministère du Développement social, le Programme de pension d'invalidité du Régime de pensions du Canada, le système d'assurance-maladie provincial ou territorial et les services locaux d'aide sociale.

> La liste des prestataires possibles de service est longue, l'interrelation entre les différents programmes est complexe, et les choix à faire ne

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[118] Tribunal des anciens combattants (révision et appel), « À propos du Tribunal des anciens combattants (révision et appel) » http://www.vrab-tacra.gc.ca/IciTACRA.htm.

[119] Ombudsman Ontario, « *The Case for a VAC Ombudsman — Esprit de Corps* », juillet 2005. [traduction]

> sont pas toujours clairs. Parfois, les prestations obtenues d'un programme privent des prestations d'un autre. Tout ça est d'une administration fastidieuse et nuit à la qualité du service[120].

M. Ferguson a bien montré comment un responsable de dossier pouvait intervenir pour simplifier la vie d'un client qui a perdu son revenu et sa carrière. Une telle personne peut aider le client et sa famille à composer avec le déséquilibre psychologique et à s'y retrouver dans le dédale des programmes :

> *Il s'agit du cas d'un ancien combattant de 40 ans qui touche une pension établie à 80 p. cent. Ce client souffre du syndrome de stress post-traumatique par suite de son service dans une zone de service spécial, et il a des tendances suicidaires. Sa femme et ses enfants l'ont quitté parce qu'ils craignaient pour leur propre sécurité. Après son congé de l'hôpital, ses appels au secours sont restés sans réponse, les organismes locaux n'ayant pas les ressources nécessaires pour lui venir en aide en cette période difficile, ce qui n'est pas inusité. Il a appelé le service d'aide d'ACC et a parlé à un conseiller de secteur qui s'est mis en rapport avec le bureau de district compétent pour explorer les possibilités d'aide à sa disposition. Au départ, nous avions conclu une entente avec nos partenaires des États-Unis pour que le client y reçoive des traitements, mais il s'est ensuite présenté une possibilité d'aide à l'échelle locale. En effet, grâce à nos partenariats avec le MDN, et les praticiens locaux, le centre de soutien pour trauma et stress opérationnels du MDN de la région a pu lui dispenser des traitements. Par la suite, le bureau local de district d'ACC prendra son cas en charge et maintiendra le contact avec les cliniciens*[121].

13.4.3.3 Prestation de services

Anciens Combattants Canada a du mal à obtenir des services offerts par des fournisseurs provinciaux.

Anciens Combattants Canada, comme les autres ministères fédéraux qui ont des clients aux prises avec des problèmes de santé mentale, a du mal à obtenir des services offerts par des fournisseurs provinciaux. M. Ferguson a expliqué que le ministère cherche à adopter une approche d'intervention précoce pour éviter que les problèmes de santé mentale ne s'aggravent :

> *À l'heure actuelle, comme il est difficile pour ACC, sans parler du MDN et de la population du Canada, de mettre la main sur des services d'aide psychiatrique, nous dépensons nos énergies sur l'intervention*

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120 Anciens Combattants Canada - Conseil consultatif sur les Forces canadiennes, *Respecter l'engagement du Canada : offrir « possibilités et sécurité » aux anciens combattants des Forces canadiennes et à leurs familles au XXIe siècle*, mars 2004 [traduction] http://www.vac-acc.gc.ca/clients/sub.cfm?source=councils/vaccfac/commitment.

121 23 février 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/08ev-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

précoce en vue de détecter les problèmes au tout début et ainsi éviter que ne surviennent des situations graves. De plus, nos professionnels de la santé dans les bureaux de district peuvent non seulement intervenir au nom des clients et les aider à recevoir les soins qu'il faut, mais ils peuvent suivre de près leurs progrès après un épisode critique[122].

La télésanté est une solution prometteuse tant pour le Ministère que pour les clients.

La télésanté est une solution prometteuse tant pour le Ministère que pour les clients. Anciens Combattants Canada, en collaboration avec la faculté de médecine de l'université Memorial de Terre-Neuve, utilise la technologie de la vidéoconférence pour mettre les clients en rapport avec des psychologues[123].

Le Dr Ted Callanan, président, Psychiatric Association of Newfoundland and Labrador, a commenté le programme de soutien social et de traitement qu'ACC met à la disposition de ceux qui souffrent de syndrome de stress post-traumatique ou d'autres problèmes liés au service militaire. Il a indiqué que si certains clients choisissent de venir à St. John's, où se trouvent la plus grande partie des services, la télésanté offre une autre possibilité à ceux qui vivent ailleurs dans la province :

[I]ls peuvent maintenant avoir accès à leurs conseillers via la technologie de la télésanté, et c'est en fait plutôt populaire. On s'est interrogé pour savoir pourquoi certaines personnes choisissent d'utiliser les centres de télésanté dans les petites villes, quelque chose qui commence maintenant à se faire en Nouvelle-Écosse et ailleurs au pays. Ce n'est pas pour remplacer ce qui existe, mais pour offrir aux anciens combattants une autre façon d'y avoir accès. (15 juin 2005)

13.4.4 Commentaire du Comité

Le Comité s'inquiète du fait que les anciens combattants n'ont pas accès à une instance comme celle de l'Ombudsman des Forces canadiennes. Il voit les mérites d'un organisme indépendant et objectif chargé d'étudier les griefs des anciens combattants et de faire des recommandations.

Le Comité voit d'un bon œil les efforts visant à optimiser la façon dont la santé mentale est évaluée et dont sont indemnisés les anciens combattants qui ont subi des blessures ou des traumatismes. Il se réjouit des efforts consentis pour créer des partenariats et mieux coordonner les activités d'ACC et du MDN. La mise en réseau de ces deux ministères favorisera une amélioration des services offerts aux membres des FC et aux autres clients.

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122 23 février 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/08ev-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

123 Anciens Combattants Canada, *Aide à la communauté militaire*, http://www.vac-acc.gc.ca/clients-f/sub.cfm?source=salute/osi_edition/cf_support.

Comme c'est le cas pour d'autres groupes de clients fédéraux, le Comité craint que le Parlement ne soit pas au courant de tous les efforts qui sont faits pour faciliter la transition vers la vie civile et donner une bonne qualité de vie aux anciens combattants frappés d'invalidité.

Par conséquent, le Comité recommande :

78	**Qu'Anciens Combattants Canada, conjointement avec le ministère de la Défense nationale, établisse un relevé annuel des programmes et services de santé mentale, indiquant le nombre de clients desservis, les budgets accordés et les sommes dépensées, et les résultats obtenus.** **Que ce rapport soit soumis au Parlement tous les ans à compter de 2008.**

Le Comité s'inquiète du fait que les anciens combattants n'ont pas accès à une instance comme celle de l'Ombudsman des Forces canadiennes. Il voit les mérites d'un organisme indépendant et objectif chargé d'étudier les griefs des anciens combattants et de faire des recommandations.

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Le Comité recommande :

79	**Que le gouvernement du Canada crée à l'intention des anciens combattants une instance semblable à celle de l'Enquêteur correctionnel, de l'Ombudsman des Forces canadiennes ou du Comité externe d'examen de la GRC.** **Que cette instance soit habilitée à enquêter sur des plaintes individuelles de même que sur des préoccupations générales portant sur la prestation même des programmes et services fédéraux ayant une incidence sur le bien-être mental des anciens combattants.** **Que cette instance fasse rapport au Parlement à tous les ans.**

13.5 LA GENDARMERIE ROYALE DU CANADA

> *[L]es méthodes traditionnelles de maintien de l'ordre n'apportent pas les résultats souhaités lorsqu'il est question d'intervenir auprès d'une personne atteinte d'une maladie mentale. — Shirley Heafey, présidente, Commission des plaines du public contre la GRC*[124]

13.5.1 La compétence fédérale

Selon la *Loi canadienne sur la santé*, « les membres de la Gendarmerie royale du Canada nommés à un grade » sont exclus de la définition de l'« assuré ». La Gendarmerie royale du Canada est régie par la *Loi sur la Gendarmerie royale du Canada*[125], qui détermine les qualités requises pour être membre de la GRC. Le *Règlement de la Gendarmerie royale du Canada* établit les conditions dans lesquelles un membre régulier ou un membre spécial peut avoir accès à des services médicaux sous réserve de l'approbation du commissaire [126]. Au 31 mars 2005, la GRC comptait 22 557 employés, comprenant les membres réguliers, les membres civils et les fonctionnaires[127].

Le *Règlement de la Gendarmerie royale du Canada* comprend un certain nombre de dispositions relatives à la santé mentale comme cause d'incapacité, mais ne fait pas de distinction entre une incapacité causée par le travail et une autre qui ne le serait pas. En ce qui concerne le renvoi par mesure administrative, « le membre, autre qu'un officier, peut être renvoyé de la Gendarmerie, et l'officier peut faire l'objet d'une recommandation de renvoi de la Gendarmerie, pour l'un des motifs suivants, *a*) incapacité physique ou mentale après examen par un conseil médical ».

Les membres de la Gendarmerie royale du Canada qui deviennent invalides par suite d'une mission en service spécial [128] et qui ont par conséquent été démis de leurs fonctions à la GRC ont le droit d'être nommés en priorité à un poste de la fonction publique pour lequel ils sont compétents [129]. De plus, après leur retraite obligatoire, la *Loi sur la pension de retraite de la Gendarmerie royale du Canada* précise que le prestataire de prestations supplémentaires peut être :

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124 10 mai 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/15evc-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

125 *Loi sur la Gendarmerie royale du Canada*, L.R.C. 1985, ch. R-10, http://lois.justice.gc.ca/fr/R-10/index.html.

126 *Règlement de la Gendarmerie royale du Canada*, 1988 (SOR/88-361) http://lois.justice.gc.ca/fr/R-10/SOR-88-361/174146.html.

127 Gendarmerie royale du Canada, *Rapport sur le rendement pour la période se terminant le 31 mars 2005* http://www.tbs-sct.gc.ca/rma/dpr1/04-05/RCMP-GRC/RCMP-GRCd4502_f.asp#glance.

128 On entend par service spécial la participation à un conflit armé, une mission de maintien de la paix, des activités anti-terroristes, une opération de secours aux sinistrés ou une opération de recherche et de sauvetage.

129 Commission de la fonction publique, *Admissibilité à une nomination prioritaire — membres des Forces canadiennes ou de la Gendarmerie royale du Canada qui deviennent handicapés*, http://www.psc-cfp.gc.ca/staf_dot/priority-priorite/rcmp-grc_f.htm.

une personne qui, n'ayant pas atteint l'âge de soixante ans, reçoit une pension à l'issue de sa retraite obligatoire de la Gendarmerie au motif que son état de santé physique ou mentale l'a rendue invalide[130].

En 2003, Anciens Combattants Canada a pris en charge la responsabilité d'administrer la pension d'invalidité et les prestations de soins de santé des membres de la GRC qui touchent une pension en raison d'une blessure ou d'une maladie liée à leur travail. ACC est ainsi devenu responsable des versements directs de pension d'invalidité à environ 3 800 pensionnés de la GRC et de la prestation de services de santé à environ 800 policiers et civils retraités [131]. Au début de 2005, on estimait que ACC desservait plus de 5 000 clients de la GRC, dont 300 survivants d'un membre de la GRC touchant une pension [132].

13.5.2 Programmes et services fédéraux

Le Comité externe d'examen de la GRC a été créé en 1988 pour procéder à l'examen impartial de certains griefs et en appeler de certaines mesures disciplinaires. Une fois son examen terminé, le Comité fait des recommandations au commissaire du la GRC, qui rend une décision finale mais doit justifier sa décision lorsqu'elle diffère de celle du Comité.

Le manque de formation sur les moyens de réagir aux manifestations publiques de maladie mentale semble être endémique et bien ancré dans les rouages internes de la GRC.

Le juge a affirmé que la formation de la GRC en ce qui concerne les maladies mentales était inexistante ou insuffisante.

— *Shirley Heafey*

Divers rapports du Comité externe d'examen permettent de glaner des renseignements sur les problèmes de santé mentale, de maladie mentale et de toxicomanie des membres de la GRC, notamment les congés de maladie, les insuffisances de rendement et la dépendance à l'alcool qui résultent des facteurs de stress auxquels sont soumis les membres de la GRC [133]. Certains cas de congédiement pour conduite déshonorante, soumis au Comité externe d'examen de la GRC, ont révélé des facteurs de stress qui ont conduit à un ordre de démission volontaire sous peine de congédiement ou à un renvoi pour motif médical, en raison d'incapacité psychologique.

Un certain nombre de témoins ont parlé au Comité du manque de sensibilité des policiers de la GRC dans leur façon de traiter les civils atteints de maladie mentale. Ils signalent que le manque de formation sur les moyens de réagir aux manifestations publiques de maladie mentale semble être endémique et bien ancré dans les rouages internes de la GRC. À cet

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130 *Loi sur la pension de retraite de la Gendarmerie royale du Canada*, L.R.C. 1985, ch. R-11, http://lois.justice.gc.ca/fr/R-11/texte.html.

131 Gendarmerie royale du Canada, « Anciens Combattants Canada et la Gendarmerie royale du Canada unissent leurs efforts pour offrir de meilleurs services », *Communiqué de presse de la GRC*, 17 février 2003.

132 GRC, « La nouvelle charte des anciens combattants — Message de la dirigeante principale des ressources humaines », 24 mai 2005, http://www.rcmp.ca/vets/new_charter_f.htm#top.

133 Comité externe d'examen de la gendarmerie royale du Canada, *Publications*, comprend notamment des rapports de recherche et des communiqués sur des cas particuliers, http://www.erc-cee.gc.ca/français/publications_date_f.html.

égard, Shirley Heafey, présidente de la Commission des plaintes du public contre la GRC, a déclaré au Comité que :

> *En 2003, la GRC a fait l'objet d'une enquête judiciaire sur la mort par balle d'une personne en état de crise. Le juge a affirmé que la formation de la GRC en ce qui concerne les maladies mentales était inexistante ou insuffisante et que les trois membres de la GRC visés dans cette affaire accepteraient volontiers de recevoir une formation plus approfondie et adéquate*[134].

Doris Ray a raconté au Comité son expérience vécue en qualité de membre de la famille :

> *L'agent a raconté qu'il avait pris connaissance des symptômes de la schizophrénie par son beau-frère qui en souffrait. Sa formation dans la GRC, souvent le premier recours pour les familles en situation de crise, surtout dans les petits villages, comprenait très peu d'information sur la façon de reconnaître et de traiter les symptômes de la psychose. J'ai récemment demandé à un jeune officier s'il avait reçu plus de formation à ce sujet, et il m'a répondu qu'on en donne encore moins qu'avant*[135].

En général, la GRC offre un ensemble de services de santé pour faire en sorte que ses membres réguliers soient physiquement et émotionnellement en mesure d'exercer leurs fonctions. Lorsqu'un membre actif de la GRC utilise un service offert par la province, il présente son numéro de client qui témoigne de l'autorisation donnée par un agent des services de santé de la GRC; le service de santé facture alors la GRC. Chaque division de la GRC a généralement un médecin comme agent régional des services de santé, ainsi qu'un psychologue régional et un nombre variable d'infirmières en santé du travail.

Les policiers s'imaginent que d'admettre l'existence d'un problème et demander de l'aide sont des signes de faiblesse.

Une étude réalisée en 1992 a établi trois grandes sources de stress professionnel pouvant entraîner chez les policiers des symptômes relativement courants de maladie mentale comme la dépression, l'épuisement professionnel et le suicide[136] :

- facteurs externes : comparutions devant un tribunal, contre-interrogatoires, attente prolongée de décisions judiciaires, manque d'encouragement de la population, relations avec les minorités et image de la police véhiculée par les médias;

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134 10 mai 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/15evc-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

135 6 juin 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/18eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

136 Comité externe d'examen de la Gendarmerie royale du Canada, *La santé et la sécurité au travail — une optique patronale*, Document de recherche 9, 1992 http://www.erc-cee.gc.ca/Discussion/francais/fDP9.htm.

- facteurs internes : structure du corps policier, manque de participation à l'organisation du travail, problèmes de communication, manque de soutien de la part des supérieurs, excès de bureaucratie, formation, évaluation de rendement, salaire, promotion, manque de ressources humaines et matérielles;

- facteurs liés au travail : travail intensif suivi de périodes d'inactivité, rôles conflictuels et ambigus, perception de danger, complexité des tâches, manque d'autonomie, sentiments ambigus, exposition à la misère, à la douleur et à la mort.

Cette étude a établi un rapport entre les facteurs de stress professionnel et certains comportements comme une productivité réduite, un temps de réaction plus long, les erreurs de jugement, l'insatisfaction au travail, le goût de démissionner, l'absentéisme et les accidents[137]. Un autre rapport, portant sur les programmes d'aide aux employés, a fait ressortir la difficulté de mettre de tels programmes en œuvre en milieu policier, car les services de police constituent souvent une « société fermée » et les policiers s'imaginent que d'admettre l'existence d'un problème et demander de l'aide sont des signes de faiblesse[138].

Quand la GRC recrute des psychologues, « elle offre 20 000 à 30 000 dollars de moins que dans les hôpitaux.

Les services offerts aux agents de la GRC par les services de santé de la GRC sont variables. Les agents des services de santé assurent la gestion de cas — évaluation, aiguillage et suivi vers des programmes de traitement de l'alcoolisme et de la toxicomanie et problèmes personnels connexes [139]. Dorothy Cotton, psychologue et coprésidente de Canadian National Committee for Police/Mental Health Liaison, dit que quand la GRC recrute des psychologues, « elle offre 20 000 à 30 000 dollars de moins que dans les hôpitaux ». Elle ajoute qu'on « ne peut recruter des gens quand on propose aussi peu. Et que cela en dit long sur la façon dont la GRC considère la profession »[140].

13.5.3 Évaluation des besoins du groupe client

La GRC a récemment annoncé qu'elle était inscrite parmi les meilleurs employeurs du pays dans l'édition 2006 de *Canada's Top 100 Employers* [141]. Ses propres sondages sur le rendement de 2003-2004, toutefois, révélaient des problèmes liés au moral, au milieu de travail, aux communications, aux outils et à la formation, à la charge de travail, aux responsabilités et aux systèmes de soutien. Selon les sondages, le taux de satisfaction au travail s'établissait à 61 p. cent; « bien que les employés soient fiers de la GRC et de leur travail, ils sont

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137 *Ibid.*

138 Comité externe d'examen de la Gendarmerie royale du Canada, *Programmes d'aide aux employés — Philosophie, théorie et pratique,* Document de recherche 5, 1990 http://www.erc-cee.gc.ca/Discussion/francais/fDP5.htm.

139 Santé Canada, *Profil — Alcoolisme et toxicomanie Traitement et réadaptation au Canada*, « Rôle du gouvernement fédéral dans le traitement de l'alcoolisme et des toxicomanies », 1999 http://www.hc-sc.gc.ca/ahc-asc/pubs/drugs-drogues/profile-profil/federal_f.html.

140 16 février 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/06eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

141 GRC, *Communiqué de presse*, « La GRC figure sur la liste des 100 meilleurs employeurs », 18 octobre 2005, http://www.rcmp-grc.gc.ca/news/n_0524_f.htm.

préoccupés par certaines questions comme la charge de travail, l'équité et le perfectionnement professionnel »[142].

En 2002, Norman Sabourin, directeur exécutif et avocat principal du Comité externe d'examen, a écrit un article intitulé « Le renvoi pour raisons médicales et le devoir d'accommodement à la GRC ». Dans sa conclusion, il soutient que la GRC devra « prendre les mesures d'accommodement qui conviennent pour tout membre ayant une déficience qui voudra continuer à travailler, ou bien il faudra prouver que la GRC subirait une contrainte excessive si elle prenait de telles mesures ». Il ajoute que « cela exigera que l'on apporte des changements importants aux politiques existantes »[143].

La GRC n'est pas visée par la nouvelle charte des anciens combattants et se trouve donc exclue des propositions de changements aux programmes et services d'ACC destinés aux clients des FC.

On constate une disparité entre les services et prestations d'invalidité offerts aux membres de la GRC et ceux qui sont offerts aux autres clients desservis par Anciens Combattants Canada. Par exemple, les membres de la GRC n'ont pas accès aux services du Programme pour l'autonomie des anciens combattants (soins à domicile, adaptations domiciliaires, transport, services de soins ambulatoires et infirmière à domicile). ACC se dit prêt à envisager des moyens de combler ces lacunes :

> Jusqu'ici, la recherche effectuée de concert avec la GRC révèle que même si elle ne partage pas les mêmes points de vue, attitudes et mentalités que les clients des FC, la GRC comprend et semble s'identifier aux questions qui préoccupent les FC. Nul doute que cela est attribuable au fait que les deux groupes ont travaillé dans des contextes et environnements similaires, ou y ont été exposés. Cela comprend des déploiements dans des opérations de maintien de la paix ou dans des zones de service spécial. Afin d'aborder correctement le problème des lacunes concernant les services/avantages, le personnel d'ACC devra recevoir la formation nécessaire pour mieux comprendre la GRC et la culture de la « gendarmerie »[144].

Cependant, la GRC n'est pas visée par la nouvelle charte des anciens combattants et se trouve donc exclue des propositions de changements aux programmes et services d'ACC destinés aux clients des FC. La GRC a dit préférer faire sa propre évaluation des besoins :

> La GRC a choisi de procéder à une évaluation des besoins de ses membres actifs et à la retraite relativement à des services et des programmes modernisés. Cette évaluation est nécessaire en raison de

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142 GRC, *Rapport de rendement 2003-2004*, http://www.tbs-sct.gc.ca/rma/dpr/03-04/RCMP-GRC/RCMP-GRCd3401_f.asp#Lines.

143 Norman Sabourin, « Le renvoi pour raisons médicales et le devoir d'accommodement à la GRC » Comité externe d'examen, mars 2002, http://www.erc-cee.gc.ca/francais/articles/articles_medicaldischarge_f.html.

144 Anciens Combattants Canada, *Mise en œuvre de nos priorités,Plan stratégique quinquennal — Mise à jour 2004* http://www.vac-acc.gc.ca/general_f/sub.cfm?source=department/reports/update 2004/ action04.

> la différence considérable qui existe sur le plan des profils, des rôles, des cheminements de carrière et des qualités requises des présents membres de la GRC et des FC. Par conséquent, les besoins des membres de la GRC peuvent être très différents de ceux des membres des FC[145].

Plusieurs associations de retraités de la GRC ont commenté une lettre provenant du commissaire de la GRC disant qu'un Groupe de travail sur la modernisation des programmes et services d'invalidité avait été créé et allait procéder à une analyse globale des besoins. On se proposait d'examiner les services offerts en vertu de la *Loi sur les pensions* de même que l'accès aux soins de longue durée et aux services de maintien à domicile (Programme pour l'autonomie des anciens combattants) qui vont au-delà de ce qui est couvert par l'allocation pour soins [146]. Prétextant d'autres priorités, la GRC a déjà plusieurs fois remis à plus tard la réalisation de cette analyse et, bien qu'un rapport ait été promis pour l'automne 2005, rien n'avait encore paru au début de 2006.

13.5.4 Commentaire du Comité

Le Comité est au courant des efforts de la GRC pour répondre aux besoins de ceux de ses membres qui ont fait des demandes de prestations d'invalidité, dont certaines pour raisons de santé mentale. Il faut cependant que plus d'information soit rendue publique sur ce groupe de clients.

Le Comité veut savoir si la GRC offre du counselling à ses employés après un événement traumatisant, ou à ses employés et leur famille après une réinstallation stressante. Il veut aussi savoir comment la GRC s'occupe des besoins de transition de ses membres lorsqu'ils quittent la Gendarmerie, et déterminer quels ajustements il faudrait apporter aux lois, aux politiques et programmes de santé, et aux mécanismes de prestation de services pour qu'ils aient un accès approprié aux services.

Le Comité veut savoir si la GRC offre du counselling à ses employés après un événement traumatisant, ou à ses employés et leur famille après une réinstallation stressante. Il veut aussi savoir comment la GRC s'occupe des besoins de transition de ses membres lorsqu'ils quittent la Gendarmerie, et déterminer quels ajustements il faudrait apporter aux lois, aux politiques et programmes de santé, et aux mécanismes de prestation de services pour qu'ils aient un accès approprié aux services.

Le Comité ne sait pas quelle formation est donnée aux agents de la GRC pour les aider à mieux comprendre la maladie mentale.

Par ailleurs, le Comité ne sait pas quelle formation est donnée aux agents de la GRC pour les aider à mieux comprendre la maladie mentale. Les témoins ont suggérés que cette formation est très limitée, voire inexistante. Une formation sur la maladie mentale et les toxicomanies pourrait non seulement aider les agents à mieux intervenir auprès de la population civile, mais pourrait aussi les aider à mieux comprendre les problèmes de santé mentale lorsqu'ils se manifestent chez leurs collègues.

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145 GRC, « La nouvelle charte des anciens combattants — Message de la dirigeante principale des ressources humaines » mai 2005, http://www.rcmp.ca/vets/new_charter_f.htm#top.

146 Association des anciens de la GRC, Division de Calgary, « Notes of Interest », http://www.members.shaw.ca/rcmpvets.calgary/notes.htm.

Le Comité recommande :

80	**Que le gouvernement fédéral subventionne un programme de formation des membres de la GRC sur la maladie mentale et les toxicomanies.** **Que la GRC publie dès que possible en 2006 les résultats de l'analyse réalisée par le groupe de travail chargé d'étudier la question de l'invalidité à la GRC et les besoins en programmes et services.** **Que la GRC crée un programme d'entraide pour ses membres, inspiré du modèle d'ACC/MDN dans le domaine du stress post-traumatique.** **Que la GRC inscrive ces initiatives ainsi que d'autres programmes et services dans un relevé annuel des programmes et services offerts aux agents de la GRC.** **Que ce relevé soit soumis au Parlement tous les ans à compter de 2008.**

Le Comité se réjouit du fait que la GRC ait créé un Comité externe d'examen pour faire enquête sur des questions de toutes sortes. Cet organisme semble bien placé pour analyser en profondeur les besoins de santé mentale des membres de la GRC.

Le Comité recommande :

81	**Que le Comité externe d'examen de la GRC procède à l'analyse des besoins de santé mentale des membres actifs et retraités de la GRC et fasse rapport au Parlement d'ici 2007.**

13.6 LES IMMIGRANTS ET RÉFUGIÉS

> *Le réseau de santé mentale reconnaît la nécessité de traiter le syndrome post-traumatique, sans toutefois reconnaître le problème du racisme, ce traumatisme quotidien que subissent les réfugiés; tant qu'aucune solution ne sera apportée à ce problème, l'approche restera inefficace. — Martha Ocampo, codirectrice, Across Boundaries, Ethnoracial Mental Health Centre, Toronto*[147]

[147] 17 février 2005, [modifié par le traducteur] http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/07ev-f.htm?Language=F&Parl=38&Ses=1&comm_id=47

13.6.1 La compétence fédérale

Toutes les personnes qui demandent la résidence permanente et certains qui demandent l'admission temporaire au Canada (visiteurs, étudiants et travailleurs) doivent subir un examen physique et mental

Citoyenneté et Immigration Canada (CIC) est responsable de l'admission au Canada des immigrants, des étudiants étrangers, des visiteurs, des travailleurs temporaires et des réfugiés. Comme le décrit la D^re^ Sylvie Martin, directrice intérimaire, Élaboration du programme de santé de l'immigration, Direction générale des services médicaux, Citoyenneté et Immigration Canada :

> *Selon la Loi de l'immigration et de la protection des réfugiés et sa réglementation, le ministère admet des immigrants et des résidents temporaires qui contribuent à la croissance du Canada, sur le plan économique et social, réinstalle, protège et offre un asile aux réfugiés, aide les nouveaux arrivants à s'adapter à la société canadienne, et éventuellement à acquérir la citoyenneté et gère l'accès au Canada, de manière à protéger la sécurité et la santé des Canadiens et des Canadiennes, ainsi que l'intégrité des lois canadiennes*[148].

Après l'admission au Canada, la prestation de programmes et de services liés à la santé mentale est censée relever du système public et devenir une responsabilité provinciale ou territoriale.

Sous le régime de la *Loi sur l'immigration et la protection des réfugiés*, toutes les personnes qui demandent la résidence permanente et certains qui demandent l'admission temporaire au Canada (visiteurs, étudiants et travailleurs) doivent subir un examen physique et mental [149]. Selon les résultats de cet examen, un demandeur peut se voir refuser l'entrée au Canada si son état de santé physique ou mentale risque vraisemblablement de constituer un danger pour la santé ou la sécurité publique, ou de représenter un trop lourd fardeau pour le système de santé ou les services sociaux. L'information provenant du Ministère ne donne aucune indication précise sur la façon d'agir lorsque le candidat présente un problème de santé mentale.

On entend par « fardeau excessif » le « fardeau imposé aux services sociaux et de santé du Canada en raison d'une hospitalisation permanente ou de soins médicaux, sociaux ou en établissement à l'égard de maladies physiques ou mentales, ou touchant des services d'éducation ou de formation spécialisées »[150]. Pour déterminer si le candidat risque de représenter un fardeau excessif, un médecin désigné par le Ministère étudie le diagnostic, le pronostic, et les besoins en services sociaux ou médicaux de la personne sur un certain nombre d'années (généralement cinq ans). Le médecin établit ensuite les coûts de ces besoins sur une période de cinq ans *et* détermine s'il y a des listes d'attente pour certains de ces services. Si les montants sont supérieurs au coût par habitant des services sociaux et médicaux d'un Canadien moyen, sur cinq ans, ou s'il y a des listes d'attente pour certains des

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148 23 février 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/08ev-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

149 Loi sur l'immigration et la protection des réfugiés, 2001, ch. 27, http://lois.justice.gc.ca/fr/I-2.5/.

150 Citoyenneté et Immigration Canada, Demande de résidence permanente au Canada, « Annexe D : examens médicaux », 2004, http://www.cic.gc.ca/francais/demandes/guides/4000F_D.html.

services nécessaires, le candidat sera jugé inadmissible[151]. Certains groupes désignés au paragraphe 38(2) de la *Loi sur l'immigration et la protection des réfugiés* sont « dispensés du critère de fardeau excessif » et ne se voient pas refuser l'entrée au pays en raison d'éventuels besoins de santé[152].

Après l'admission au Canada, la prestation de programmes et de services liés à la santé mentale est censée relever du système public et devenir une responsabilité provinciale ou territoriale. Mais tout dépend du temps que met le fédéral à régler le dossier du demandeur et de l'entente intervenue entre le fédéral et la province ou le territoire en ce qui concerne les services d'établissement et d'intégration. Les immigrants reçus sont censés (mais n'y parviennent pas toujours) s'occuper de leurs besoins de santé, en prenant notamment une assurance privée pour couvrir les trois mois de la période d'attente qui a cours dans quatre provinces (Colombie-Britannique, Ontario, Québec et Nouveau-Brunswick) avant l'adhésion au régime public[153].

Dans son rapport de rendement déposé au Parlement en 2005, CIC indique qu'en 2004, un total de 235 824 personnes ont été admises au Canada à titre de résidents permanents[154]. Le Ministère précise que de ces nouveaux arrivants :

- 57 p. cent (133 746) étaient des immigrants économiques avec personnes à charge;
- 26 p. cent (62 246) entraient dans la catégorie famille;
- 14 p. cent (32 685) étaient des réfugiés et autres demandeurs d'asile;
- 3 p. cent (6 945) ont eu un statut de résident permanent pour raisons humanitaires.

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151 Lettre de la Dre Sylvie Martin, directrice intérimaire, Élaboration du programme de santé de l'immigration, Direction générale des services médicaux, Citoyenneté et Immigration Canada au sénateur Michael Kirby, président, Comité sénatorial permanent des affaires sociales, des sciences et de la technologie, le Sénat, 3 février 2006.

152 Les époux et conjoints de fait, les partenaires conjugaux, et les enfants à charge parrainés à titre de membres de la catégorie famille, les réfugiés et les demandeurs d'asile ainsi que les personnes à leur charge ne peuvent être refusés sur le motif qu'en raison de leur état de santé elles constitueraient un fardeau excessif pour les services sociaux et médicaux; CIC, *Examen médical et Surveillance*, Fiche de renseignements 20, http://www.cic.gc.ca/francais/lipr/fiche-medical.html.

153 Anita Gagnon, *La réceptivité du système canadien de soins de santé à l'égard des nouveaux arrivants*, Étude no 40, Commission sur l'avenir des soins de santé au Canada, novembre 2002, http://www.hc-sc.gc.ca/francais/soins/romanow/hcc0426.html.

154 Citoyenneté et Immigration Canada, *Rapport sur le rendement pour la période se terminant le 31 mars 2005*, p. 61, http://www.tbs-sct.gc.ca/rma/dpr1/04-05/CI-CI/CI-CId45_f.pdf.

13.6.2 Programmes et services fédéraux

13.6.2.1 Programme fédéral de santé intérimaire

Le rôle direct de Citoyenneté et Immigration Canada dans la prestation de services de santé s'exerce dans le cadre du Programme fédéral de santé intérimaire. Ce programme, créé par décret en 1957, est passé de Santé Canada à Citoyenneté et Immigration Canada en 1995. Comme l'indique la D[re] Martin :

> *[I]l assure des services de santé aux migrants, population qui englobe actuellement les demandeurs du statut de réfugié, les réfugiés, les détenus dans les centres de détention de l'immigration et les demandeurs déboutés encore présents au Canada qui sont incapables de payer les soins de santé dont ils ont besoin. Les soins visés comprennent les services médicaux essentiels et d'urgence, notamment les services de santé mentale, comme les visites chez le médecin, l'hospitalisation et les médicaments essentiels. Les sommes déboursées pour le programme se sont chiffrées à 51 millions de dollars en 2002-2003, tandis que le nombre d'utilisateurs s'élevait à 97 000 et le nombre de demandes à 700 000* [155].

Le rôle direct de Citoyenneté et Immigration Canada dans la prestation de services de santé s'exerce dans le cadre du Programme fédéral de santé intérimaire.

L'administration de ce programme a été confiée à FAS (Funds Administrative Service Inc.), une firme d'administrateurs de prestations d'Edmonton. Les services de santé mentale prévus par le Programme fédéral de santé intérimaire sont limités, mais comprennent la consultation d'un psychiatre, l'hospitalisation pour troubles psychiatriques, une rencontre initiale de psychothérapie avec un médecin (le suivi sera couvert si approuvé) et la médication essentielle.

Le Ministère n'a pas fourni la ventilation des dépenses affectées à la maladie mentale ou aux toxicomanies. On peut raisonnablement présumer toutefois qu'elles sont élevées car bon nombre de demandeurs du statut de réfugié ont subi la torture et vécu d'autres situations éprouvantes pour la santé mentale.

Certaines provinces ont exprimé des doutes quant à la capacité du Programme fédéral de santé intérimaire de couvrir la totalité des coûts des services de santé liés à l'immigration. Elles demandent qu'on révise le niveau des honoraires admis, la portée des services et le remboursement des frais engagés par la province pour fournir des services. Par exemple, l'accord de 2004 conclu avec la Colombie-Britannique en vertu de la *Loi sur l'immigration et la protection des réfugiés* signale la nécessité d'examiner les coûts qu'entraînent pour la province l'obligation d'offrir des services aux demandeurs d'asile, aux immigrants réputés interdits de séjour pour motif sanitaire mais qui ont été autorisés à entrer en pays en vertu des nouvelles dispositions de la Loi (dispense du critère de fardeau excessif), et aux personnes admises,

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[155] 23 février 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/08ev-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

atteintes de graves problèmes de santé, durant la période d'attente de trois (3) mois prévue par le régime d'assurance-maladie de la Colombie-Britannique [156].

13.6.2.2 Autres initiatives

La D^re^ Martin indique que le Ministère dispose aussi d'autres mesures ayant pour but de contribuer de façon positive à la santé mentale des nouveaux arrivants au Canada :

> *Si la santé mentale se définit par la capacité de chaque personne de ressentir les choses, de réfléchir et d'agir de manière à mieux jouir de la vie, à mieux faire face aux défis, on peut dire que Citoyenneté et Immigration Canada est responsable de plusieurs initiatives directement ou indirectement liées à la santé mentale.*
>
> *Plusieurs de nos programmes visent à faciliter et à améliorer l'intégration sociale, culturelle, économique des nouveaux arrivants, diminuant ainsi le stress lié à l'établissement dans un nouveau pays, ceci dans l'intérêt [...] de ces nouveaux arrivants.*
>
> *Ces différents programmes visent à fournir de l'information concernant les ressources existantes et à faciliter l'accès à ces services*[157].

Citoyenneté et Immigration Canada cherche par divers programmes à atténuer le stress de l'intégration à la société canadienne :

- Le Programme d'établissement et d'adaptation des immigrants subventionne des organismes fournisseurs de services pour qu'ils offrent des services de consultation non thérapeutique aux nouveaux arrivants et notamment des aiguillages vers des services d'éducation, d'aide juridique, d'emploi et de logement, de même que des services sociaux et sanitaires.

- Le Programme d'accueil subventionne le recrutement, la formation, le jumelage et la coordination de bénévoles qui aident les nouveaux arrivants à trouver des solutions à leurs problèmes d'éducation et de santé et les aident à trouver dans leur collectivité les services dont ils ont besoin.

- Le Programme d'aide au réétablissement offre du soutien au revenu et toute une gamme de services immédiats. Aux réfugiés ordinaires, le Ministère accorde jusqu'à 12 mois de soutien au revenu; pour ceux qui ont des besoins particuliers, on peut aller jusqu'à 24 mois. Les montants sont déterminés selon les grilles d'aide sociale des provinces.

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156 Citoyenneté et Immigration Canada, *Accord de collaboration Canada-Colombie-Britannique en matière d'immigration*, « Annexe H — santé et immigration » http://www.cic.gc.ca/francais/politiques/fed-prov/cb-2004-annexe-h.html.

157 23 février 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/08ev-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

Citoyenneté et Immigration Canada a aussi conclu des partenariats avec d'autres ordres de gouvernement. Par exemple, il soutient le Centre canadien pour victimes de torture et le projet Metropolis, un forum international pour la recherche et le développement de politiques sur les migrations. Par ailleurs, le groupe de travail FPT sur l'établissement et l'intégration discute de questions de nature multilatérale. À l'échelle interministérielle, des initiatives conjointes ont été mises sur pied, notamment avec l'Agence de santé publique du Canada, sur les problèmes de santé liés à la migration, de même qu'avec Industrie Canada, Ressources humaines et Développement social Canada et Santé Canada sur des projets d'information visant à faciliter l'intégration.

Citoyenneté et Immigration Canada est aussi responsable de divers programmes linguistiques, notamment le Cours de langue pour les immigrants du Canada qui s'adresse aux immigrants adultes afin de faciliter leur intégration.

13.6.3 Évaluation des besoins du groupe client

Les personnes qui entrent au Canada en qualité d'immigrants ou de réfugiés forment un groupe hétérogène. Certains sont dans la catégorie des immigrants économiques ou dans celle de la famille, d'autres sont des réfugiés et d'autres encore sont demandeurs d'asile. Certains ont déjà, à l'arrivée, l'autorisation de s'établir de façon permanente au Canada tandis que d'autres demandent à être acceptés à titre de réfugiés. Toutefois, quelle que soit la catégorie les immigrants et réfugiés sont de nouveaux arrivants qui entrent au Canada avec un bagage d'expérience unique qui déterminera dans une grande mesure la façon dont ils s'adapteront à leur nouveau pays.

Dans bien des municipalités, il n'y a ni cours de langue ni structure de soutien pour les immigrants, ce qui les prive des ressources dont ils auraient besoin pour assurer leur équilibre psychologique. Et puis, même quand il y a des cours de langue, les gens n'apprennent pas nécessairement les mots qui leur permettront d'exprimer leurs besoins de santé mentale, d'autant plus que les cours de langue visent surtout les personnes qui se destinent au marché du travail.

Soeur Mangalam Lena, franciscaine d'Ottawa, a pris la parole devant le Comité au nom des immigrants et des réfugiés. Soeur Lena, infirmière et aumônière d'hôpital, représente également l'organisme Home-based Spiritual Care. Elle a parlé de solitude, de déracinement, de blessures morales et du sentiment d'avoir été brisé comme étant autant de facteurs pouvant se répercuter sur la santé mentale d'une personne. Elle a parlé d'un programme, mis sur pied par les immigrants eux-mêmes, qui leur permet de se raconter mutuellement leur histoire. Elle explique :

> *Lorsqu'on fréquente ces immigrants, on apprend que bon nombre de ceux qui ont quitté des pays en proie à la guerre ont été témoins d'atrocités, ont vu leurs proches se faire tuer et leurs mères et leurs sœurs se faire violer. Grâce à ce nouveau programme, nous pouvons constater à quel point le fait de vivre en lieu sûr leur a apporté la paix et le réconfort*[158].

[158] 21 juin 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/23eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

Le fait d'être séparé de sa famille et de sa communauté culturelle, conjugué à l'incapacité de parler anglais ou français, peut non seulement causer une grande détresse émotionnelle mais aussi réduire l'accès aux services dont on a besoin. Même si des programmes d'enseignement de la langue sont en place, tout le monde n'y a pas accès.

Dans bien des municipalités, il n'y a ni cours de langue ni structure de soutien pour les immigrants, ce qui les prive des ressources dont ils auraient besoin pour assurer leur équilibre psychologique. Et puis, même quand il y a des cours de langue, les gens n'apprennent pas nécessairement les mots qui leur permettront d'exprimer leurs besoins de santé mentale, d'autant plus que les cours de langue visent surtout les personnes qui se destinent au marché du travail.

La tendance chez les nouveaux arrivants à sous-utiliser les services risque, avec le temps, d'avoir des conséquences fâcheuses pour le système de santé.

Il se peut aussi qu'ils aient peur qu'une consultation pour santé mentale nuise au traitement de leur dossier d'immigration.

Raymond Chung, directeur exécutif, Hong Fook Mental Health Association, Toronto recommande que des lignes directrices obligatoires visent le financement, la formation et le recours aux services d'interprètes spécialisés en santé mentale[159]. Il affirme que la tendance chez les nouveaux arrivants à sous-utiliser les services risque, avec le temps, d'avoir des conséquences fâcheuses pour le système de santé :

> *C'est seulement en adoptant des stratégies de prévention et de promotion de la santé mentale adaptées à des réalités ethnoculturelles et linguistiques que l'on pourra atteindre les objectifs du dépistage et de l'intervention précoce. Ce faisant, vous contribuerez à réduire les coûts financiers et humains pour notre société, et à long terme, les coûts associés au traitement de maladies mentales plus graves*[160].

D'autres témoins ont décrit comment certaines personnes, surtout les personnes âgées et les femmes issues de cultures traditionnelles, risquaient davantage d'avoir du mal à s'adapter à un nouveau cadre de vie. Steve Lurie, directeur exécutif de l'Association canadienne pour la santé mentale, bureau de Toronto, a dit que les immigrantes qui ont des problèmes de santé mentale ont besoin qu'on s'intéresse davantage à leur situation [161].

Robena Sirett, gestionnaire, Older Persons Adult Mental Health Services, Vancouver, indique qu'on sait très peu de choses au sujet des personnes âgées, victimes de traumatismes ou de torture, qui sont entrées au Canada en qualité de réfugiés.

> *On tente actuellement d'élaborer des programmes qui peuvent être davantage adaptés et souples, selon les réfugiés qui arrivent dans notre*

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159 17 février 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/07ev-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

160 17 février 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/07ev-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

161 17 février 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/07ev-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

> *ville [...] on ne possédait pas cette compétence interculturelle qui nous permettait de communiquer avec eux*[162].

Le racisme est peut-être une des raisons pour lesquelles les immigrants et réfugiés admissibles sous-utilisent les services de santé. Il se peut aussi qu'ils aient peur qu'une consultation pour santé mentale nuise au traitement de leur dossier d'immigration. Enfin, les obstacles linguistiques, des services culturellement insensibles et la difficulté de s'y retrouver dans le dédale du système de santé peuvent décourager les gens de s'adresser aux services à leur disposition[163].

Martha Ocampo affirme que la santé mentale et physique des nouveaux arrivants, comme celle des Canadiens en général, dépend en grande partie du milieu social. Le racisme, la pauvreté, le chômage, les mauvaises conditions de logement et le manque de soutien communautaire peuvent tous nuire à l'intégration, tout comme un rapport tendu avec les fournisseurs de services de santé mentale. Mme Ocampo a déclaré au Comité que :

> *La santé mentale des membres des communautés victimes de discrimination raciale ne peut être comprise en dehors du contexte des conditions sociales dans lesquelles elles vivent. Ces conditions sont caractérisées par les inégalités sociales qui vont déterminer les types de problèmes de santé mentale dont ils vont souffrir et qui ont une incidence sur la façon dont ces problèmes sont compris et traités par les professionnels de la santé et par le réseau de santé mentale*[164].

Pour Mme Ocampo, la participation pleine et entière dépend avant tout des mesures d'adaptation qu'on est disposé à mettre en place :

> *[V]ous devez vous rappeler que les nouveaux immigrants ou les réfugiés s'efforcent de s'établir et auront besoin de certaines adaptations pour être en mesure de participer pleinement. S'il se pose un problème pour la garde d'enfants ou pour les frais de transport, bien des choses doivent être prises en considération*[165].

13.6.4 Commentaire du Comité

Le Comité reconnaît que le Canada a la réputation d'être une terre d'asile pour le nombre croissant d'immigrants et de réfugiés qui cherchent à entrer au pays. Mais le Canada, lorsqu'il s'engage à être cette terre d'asile, *doit* garantir que les services de santé mentale seront rendus

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162 8 juin 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/20ev-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

163 Anita Gagnon, *La réceptivité du système canadien de soins de santé à l'égard des nouveaux arrivants*, Étude no 40, Commission sur l'avenir des soins de santé au Canada, novembre 2002, http://www.hc-sc.gc.ca/francais/soins/romanow/hcc0426.html..

164 17 février 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/07ev-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

165 17 février 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/07ev-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

accessibles à tous pour les aider à résoudre les problèmes de santé mentale auxquels ils font face.

D'après le Comité, il pourrait être utile que le gouvernement fédéral se dote, comme il l'a fait pour d'autres groupes de clients, d'un organisme externe chargé d'évaluer la façon dont il remplit ses engagements auprès des immigrants et des réfugiés.

Le Canada, lorsqu'il s'engage à être cette terre d'asile, *doit* garantir que les services de santé mentale seront rendus accessibles à tous pour les aider à résoudre les problèmes de santé mentale auxquels ils font face.

Par conséquent, le Comité recommande :

82	**Que le gouvernement fédéral crée une instance pour les immigrants et les réfugiés, semblable à l'Enquêteur correctionnel, à l'Ombudsman des Forces canadiennes ou au Comité externe d'examen de la GRC.** **Que cette instance soit habilitée à enquêter sur des plaintes individuelles de même que sur des préoccupations générales portant sur la prestation même des programmes et services fédéraux ayant une incidence sur le bien-être mental des immigrants et des réfugiés.** **Que cette instance fasse rapport au Parlement tous les ans**

Le Comité voit d'un bon œil la participation accrue des groupes d'immigrants et de réfugiés comme partenaires de recherche, créateurs de programmes et fournisseurs de services. Le Canada doit pousser plus loin la recherche sur l'adaptation culturelle des services de soins mis à la disposition des populations immigrantes, surtout les populations plus vulnérables que sont les enfants, les femmes et les personnes âgées.

Le Canada doit pousser plus loin la recherche sur l'adaptation culturelle des services de soins mis à la disposition des populations immigrantes, surtout les populations plus vulnérables que sont les enfants, les femmes et les personnes âgées.

La langue est un outil majeur d'intégration harmonieuse et de santé mentale pour les immigrants et les réfugiés. Tous les immigrants et les réfugiés devraient avoir accès à des cours de langue officielle. Le gouvernement fédéral a l'obligation d'offrir à ses frais des services adaptés du point de vue linguistique et culturel, et ne doit pas s'en délester aux dépens des provinces.

Le Comité recommande :

83	**Que Citoyenneté et Immigration Canada établisse un relevé annuel des ses programmes et services relatifs à la santé mentale, en indiquant notamment le nombre de clients desservis, les budgets consentis et les sommes dépensées, et les résultats obtenus, et en fasse rapport au Parlement à compter de 2008.** **Que Citoyenneté et Immigration Canada, pour faciliter l'accès aux cours de langues officielles augmente les allocations de formation, améliore les horaires de cours et offre les cours dans des lieux plus accessibles.**

13.7 LES EMPLOYÉS DE LA FONCTION PUBLIQUE FÉDÉRALE

> *Je veux évaluer ce que fait le gouvernement fédéral, comme employeur le plus important du Canada, en ce qui a trait à la santé mentale en milieu de travail. En deux mots, le gouvernement fédéral doit être un chef de file et un exemple pour tous les employeurs du pays. — L'honorable Ujjal Dosanjh, ancien ministre de la Santé*[166]

13.7.1 La compétence fédérale

En vertu des pouvoirs qui lui sont conférés par la *Loi sur la gestion des finances publiques*, le Conseil du Trésor est l'employeur de la fonction publique fédérale et le grand responsable des relations de travail, des pensions et avantages sociaux, de même que de la rémunération du personnel civil et militaire[167]. D'autres lois se répercutent aussi sur les conditions de travail des fonctionnaires fédéraux. Par exemple, la *Loi sur l'équité en matière d'emploi* oblige l'employeur fédéral à fournir les mesures d'adaptation raisonnables aux personnes handicapées[168] et la *Loi sur l'indemnisation des agents de l'État* autorise l'indemnisation des employés fédéraux pour le manque à gagner, les soins médicaux et autres préjudices causés par une blessure ou une incapacité liée au travail[169].

Selon le rapport de 2005 sur le rendement du Secrétariat du Conseil du Trésor :

> Le secteur public fédéral constitue la plus grande organisation du Canada. Doté d'un budget de dépenses de plus de 200 milliards de dollars, le gouvernement fédéral est sept fois plus grand que n'importe quelle entreprise du pays. Avec 450 000 employés, 200

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166 Agence de santé publique du Canada, communiqué de presse, « Nomination de Michael Wilson au poste de conseiller spécial du ministre pour la santé mentale », 4 février 2005.

167 *Loi sur l'administration des finances publiques,* L.R.C. 1985, ch. F-1, http://lois.justice.gc.ca/fr/f-11/text.html.

168 *Loi sur l'équité en matière d'emploi* 1995, ch.44, http://lois.justice.gc.ca/fr/e-5.401/50293.html

169 *Loi sur l'indemnisation des agents de l'État,* ch. G-5, http://lois.justice.gc.ca/fr/g-5/63537.html.

organismes, 400 millions d'opérations par année et 1 750 points of service, il s'agit sans l'ombre d'un doute de l'institution la plus complexe du pays[170].

13.7.2 Programmes et services fédéraux

La majorité des employés de la fonction publique comptent sur le gouvernement de la province ou du territoire où ils travaillent pour leurs services essentiels de santé mentale. En sa qualité d'employeur, le Conseil du Trésor établit les politiques qui régissent les régimes de soins de santé et d'assurance-invalidité des employés qui relèvent de sa compétence. Ces régimes couvrent les frais de divers services de santé mentale non prévus par les autres régimes d'assurance.

La majorité des employés de la fonction publique comptent sur le gouvernement de la province ou du territoire où ils travaillent pour leurs services essentiels de santé mentale.

En une seule année, le gouvernement fédéral a versé environ 64 millions de dollars pour des médicaments d'ordonnance et 10 millions de dollars en services de psychologues en vertu du Régime de soins de santé de la fonction publique.

Le Régime de soins de santé de la fonction publique (RSSFP) s'applique aux employés de la fonction publique, aux membres des Forces canadiennes (FC) aux membres de la Gendarmerie royale du Canada (GRC), aux retraités et à leurs personnes à charge [171]. Une Directive du RSSFP précise toutefois que seules les personnes à charge admissibles des membres des FC et de la GRC sont assurés, tandis que les membres eux-mêmes sont assurés par leurs régimes respectifs [172]. Le Régime rembourse aux adhérents la totalité ou une partie des coûts engagés pour des services admissibles, mais seulement après qu'ils aient tiré parti des services couverts par les régimes provinciaux ou territoriaux auxquels ils ont accès. Les services complémentaires comprennent notamment les services d'un psychologue sur recommandation d'un médecin, jusqu'à concurrence de 1 000 $ par année civile.

Selon Phil Charko, secrétaire adjoint, Division des avantages sociaux, Secrétariat du Conseil du Trésor, en une seule année, le gouvernement fédéral a versé environ 64 millions de dollars pour des médicaments d'ordonnance et 10 millions de dollars en services de psychologues en vertu du Régime de soins de santé de la fonction publique[173].

Le Régime d'assurance-invalidité a été conçu pour donner aux employés de la fonction publique une mesure de protection du revenu. Il procure un revenu mensuel aux employés qui sont en arrêt de travail prolongé en raison d'une maladie ou d'une incapacité qui les rend totalement invalides. Le revenu de remplacement peut aller jusqu'à 70 p. cent du salaire

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170 Conseil du Trésor, *Rapport de rendement pour la période se terminant le 31 mars 2005*, p. 13, http://www.tbs-sct.gc.ca/rma/dpr1/04-05/TBS-SCT/TBS-SCTd45_f.pdf.

171 Secrétariat du Conseil du Trésor du Canada, *Régime de soins de santé de la fonction publique — Protections et dispositions du Régime*, juillet 2001, http://www.tbs-sct.gc.ca/pubs_pol/hrpubs/TB_862/pshcpb-rssfpp_f.asp.

172 Conseil du Trésor du Canada, *Directive du Régime de soins de santé de la fonction publique*, avril 2005, http://www.tbs-sct.gc.ca/pubs_pol/hrpubs/TB_862/pshcp03_f.asp.

173 23 février 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/08ev-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

annuel. En cas d'invalidité complète, les prestations sont versées pendant une période maximale de 24 mois (état d'invalidité dû à la maladie ou à une blessure empêchant tout exercice des fonctions professionnelles). Si, à la fin de cette période de 24 mois, l'invalidité continue d'empêcher l'employé d'exercer un emploi en rapport avec ses compétences, les prestations peuvent être maintenues jusqu'à 65 ans[174].

M. Charko indique qu'en 2003, 44 p. cent des nouveaux cas d'invalidité de longue durée étaient dus à l'anxiété et à la dépression. Il estime que ce chiffre est « assez imposant » mais dit que le taux de rétablissement et de retour au travail est aussi relativement élevé. Il croit qu'environ 70 p. cent des gens qui font une demande de prestations d'invalidité de longue durée reviennent travailler à la fonction publique. Ce retour au travail exige, selon lui, que l'employeur fasse preuve de souplesse :

En 2003, 44 p. cent des nouveaux cas d'invalidité de longue durée étaient dus à l'anxiété et à la dépression. Il estime que ce chiffre est « assez imposant » mais dit que le taux de rétablissement et de retour au travail est aussi relativement élevé.

> *[N]ous sommes assez souples : on peut revenir au travail en occupant temporairement un emploi moins exigeant, ou revenir à une semaine de travail à heures réduites. Si on opte pour les heures réduites, l'assurance-invalidité est maintenue jusqu'au point du retour au niveau du revenu principal*[175].

Pour M. Charko, trois facteurs permettent à la fonction publique fédérale de bien gérer les situations mettant en cause la santé mentale :

> *Des gestionnaires bien formés qui s'intéressent aux ressources humaines, voilà un premier facteur de succès. Des politiques portant sur les congés et les mesures d'adaptation pour aider les employés aux prises avec des problèmes de santé mentale sont un autre gage de réussite. Et comme troisième élément, des programmes d'assurance destinés à aider l'employé en difficulté*[176].

M. Charko estime qu'un train de politiques en milieu de travail visant à aider les employés fédéraux à résoudre les problèmes de santé mentale, de toxicomanie et de satisfaction au travail doit comprendre les éléments suivants :

> *[...] notamment le régime de travail souple, le télétravail, le partage des postes, les politiques de mobilité, ainsi que les services de garde d'enfants.*

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174 Secrétariat du Conseil du Trésor, ch. *3-4,* Assurance-invalidité de longue durée, http://www.tbs-sct.gc.ca/pubs_pol/hrpubs/TB_865/CHAP3_4-1_f.asp.

175 23 février 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/08ev-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

176 23 février 2005 [modifié par le traducteur], http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/08ev-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

Nos politiques sont généreuses, qu'il s'agisse de politiques de congés, de lutte contre le harcèlement, de programmes de conditionnement physique, de politiques relatives au devoir d'adaptation, de l'équité en matière d'emploi, des programmes de fierté et de reconnaissance, et des politiques relatives aux codes de valeurs et d'éthique[177].

Au sujet du programme d'aide aux employés, M. Charko dit qu'il doit obligatoirement offrir dans tous les ministères du gouvernement :

[...] du counselling confidentiel à court terme payé par le ministère, qui permet d'aider les employés aux prises avec toutes sortes de problèmes, et pas seulement des problèmes de santé mentale, sans que cela nuise à leur sécurité d'emploi ou à leur carrière[178].

13.7.3 Évaluation des besoins du groupe client

Bien que la politique-cadre du gouvernement fédéral visant le soutien des employés et la création d'un milieu de travail propice au bien-être semble irréprochable, le compte rendu de personnes ayant fait l'expérience de certains programmes donne à croire que bien des choses restent encore à faire.

Il y a des employés du gouvernement fédéral dans toutes les provinces et les territoires, à l'œuvre dans des collectivités de toutes tailles, de la plus petite à la plus grande. Ces employés ont des activités de toutes sortes : inspection des aliments, météorologie, contrôle des activités de pêches, protection des frontières, surveillance des détenus en établissements correctionnels, recherche scientifique, émission de passeports, aide aux voyageurs à l'étranger, contrôle des maladies infectieuses, et bien autres choses encore.

Depuis une dizaine d'années, un certain nombre de nouveaux facteurs de stress sont présents dans le milieu de travail fédéral : la restructuration, les réductions d'effectifs, la dévolution de pouvoirs, les compressions budgétaires et l'attention des médias suscitée par les multiples scandales et controverses; voilà autant d'éléments dont l'effet cumulatif met durement à l'épreuve la santé physique et mentale des employés fédéraux.

Cette augmentation du stress au travail ressort des résultats de sondages internes réalisés par le Secrétariat du Conseil du Trésor[179]. Bon nombre de répondants ont dit travailler sous pression et se sentir déroutés par les changements constants de priorités. Les répondants ont dit vivre des situations d'instabilité dans leurs ministères et se sont plaints d'être exclus des mécanismes de prise de décision dans des secteurs ayant des répercussions directes sur leur

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177 23 février 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/08ev-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

178 23 février 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/08ev-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

179 Agence de gestion des ressources humaines de la fonction publique du Canada, *Sondage auprès des fonctionnaires fédéraux 2002, Rapport organisationnel*, http://www.hrma-agrh.gc.ca/survey-sondage/2002/results-resultats/00/result-f.htm.

travail. Vingt et un pour cent d'entre eux ont dit être victimes de harcèlement et 17 p. cent ont dit faire l'objet de discrimination au travail.

Le Conseil national mixte, organisme formé d'agents négociateurs de la fonction publique et de représentants du Conseil du Trésor, cherche des solutions fondées sur la collaboration. Il a déclaré que le Régime d'assurance-invalidité avait versé 223 millions de dollars en 2004 pour soutenir des employés touchés. Le Conseil précise que :

> En 2004, tout comme au cours des 13 dernières années, la principale cause d'invalidité invoquée dans les nouvelles demandes de prestations était les troubles psychologiques, incluant la dépression et l'anxiété. De plus en plus, les cas présentés portent moins sur des données médicales objectives et vérifiables et comportent davantage de défis posés par la difficulté du diagnostic de ces troubles[180].

M. Charko affirme que « dans un milieu de travail respectueux des différences individuelles, il est souvent possible d'éliminer le stigmate social rattaché à la maladie mentale qui est un problème dans la fonction publique ». À cet égard, le Secrétariat du Conseil du Trésor a élaboré une Politique sur l'obligation de prendre des mesures d'adaptation pour les personnes handicapées dans la fonction publique fédérale [181] en réponse à la *Loi sur l'équité en matière d'emploi* qui exige des employeurs qu'ils fassent les adaptations nécessaires pour les personnes handicapées. La définition de « personne handicapée » qui accompagne cette politique comprend notamment les personnes « qui ont une déficience durable ou récurrente soit de leurs capacités physiques, mentales ou sensorielles, soit d'ordre psychiatrique ou en matière d'apprentissage »[182].

La façon dont le gouvernement fédéral, en tant qu'employeur, traite ses psychologues contribue à la stigmatisation qui frappe la maladie mentale.

Bien que la politique-cadre du gouvernement fédéral visant le soutien des employés et la création d'un milieu de travail propice au bien-être semble irréprochable, le compte rendu de personnes ayant fait l'expérience de certains programmes donne à croire que bien des choses restent encore à faire. Par exemple, Alan Fournier, un fonctionnaire fédéral à qui on a diagnostiqué une incapacité mentale et qui a soumis un mémoire au Comité, indique qu'« il y en a à la fonction publique qui sont très compréhensifs, mais ils sont la minorité ». Il a déclaré au Comité que :

> *[S]ans vouloir pointer du doigt une personne ou un organisme de la fonction publique, le problème est plutôt systémique, résultant d'une*

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180 Conseil national mixte, *Conseil de gestion du régime d'assurance-invalidité, rapport annuel 2004*, http://www.njc-cnm.gc.ca/auxFile.php?AuxFileID=261.

181 Secrétariat du Conseil du Trésor, *Politique sur l'obligation de prendre des mesures d'adaptation pour les personnes handicapées dans la fonction publique fédérale,* 2002, http://www.tbs-sct.gc.ca/pubs_pol/hrpubs/TB_852/ppaed_f.asp.

182 Secrétariat du Conseil du Trésor, *Établir un milieu de travail accueillant pour les employés handicapés*, http://www.tbs-sct.gc.ca/pubs_pol/hrpubs/TB_852/cwwed1_f.asp

culture qui dit de bien belles choses mais n'agit pas en conséquence devant un handicap comme le mien[183].

M. Fournier mentionne aussi les limites de la prise en charge des services professionnels par le Régime de soins de santé de la fonction publique.

> *Un grand nombre de ceux, parmi nous, qui demandons les services d'un thérapeute devons nous adresser à des professionnels qui ne sont pas couverts par le Régime provincial d'assurance-maladie. Nous devons donc nous en tenir aux 1 000 $ de protection annuelle prévus par le Régime de soins de santé de la fonction publique. La plupart des psychologues et des thérapeutes en toxicomanie travaillent à 100 $ la séance. Dans mon cas, je dois m'adresser à plus d'un professionnel, dont un thérapeute en toxicomanie et un psychologue spécialisé en difficultés d'apprentissage. À leurs tarifs, je suis limité à huit rencontres par année. Une thérapie efficace, surtout aux premiers stades de la toxicomanie, doit se faire sur une base hebdomadaire. Je devrais voir mon thérapeute en toxicomanie toutes les deux semaines. J'ai aussi besoin de médicaments d'ordonnance assez coûteux. Même à 80 p. cent de remboursement, j'ai souvent du mal à payer la différence. L'obligation de payer mes frais médicaux pour ensuite me les faire rembourser fait qu'une bonne partie de mes revenus est toujours en transit, dans l'attente du règlement de mes demandes*[184].

Dorothy Cotton, psychologue et coprésidente du Canadian National Committee for Police/Mental Health Liaison, indique que dans les faits, la façon dont le gouvernement fédéral, en tant qu'employeur, traite ses psychologues contribue à la stigmatisation qui frappe la maladie mentale :

> *Le gouvernement fédéral est un mauvais employeur sur ce plan : les salaires sont facilement de 30 p. cent inférieurs à ceux du marché. C'est humiliant pour les psychologues et ça contribue à entretenir le stigmate associé à la maladie mentale*[185].

Diana Capponi, qui témoignait à titre personnel, a dit avoir appris avec enthousiasme que le ministre de la Santé avait confié à l'honorable Michael Wilson et à Bill Wilkerson la tâche d'examiner les grands enjeux entourant la santé mentale dans le milieu de travail au gouvernement fédéral. Elle exprime néanmoins des réserves :

> *[J]'avancerais que des changements s'imposent [dans la fonction publique fédérale en tant que premier employeur en importance au Canada]. J'oserais espérer que ces changements comprendront le recrutement ciblé de*

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183 Mémoire soumis le 30 mars 2005 [traduction].

184 Mémoire soumis le 30 mars 2005 [traduction].

185 16 février 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/06eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

personnes ayant des problèmes de santé mentale ou de toxicomanie, et que le gouvernement fédéral ira bien au-delà des efforts déployés par notre secteur bancaire, de façon à ce que les personnes aux prises avec un problème de santé mentale ou de toxicomanie aient accès à tous les postes, quel que soit le niveau ou la classification. Vous pourriez ainsi montrer au public canadien et à vos employés que vous « prêchez par l'exemple »[186].

13.7.4 Commentaire du Comité

Le Comité prend acte des initiatives de l'ancien ministre de la Santé, l'honorable Ujjal Dosanjh, pour centrer l'attention sur les questions de santé mentale dans la fonction publique. Citons à titre d'exemple, la nomination en février 2005 de l'honorable Michael Wilson, aujourd'hui ambassadeur aux États-Unis, au poste de conseiller spécial du ministre de la Santé en matière de santé mentale en milieu de travail au sein de l'appareil fédéral [187].

Le gouvernement fédéral, en tant qu'employeur, aurait tout intérêt à établir des liens avec le secteur privé pour découvrir des façons de faire applicables dans son propre milieu de travail, notamment pour éliminer l'opprobre qui entoure la maladie mentale.

Au chapitre 8, qui porte sur le milieu de travail en général, le Comité s'est beaucoup inspiré des travaux de la Global Business and Economic Roundtable on Addiction and Mental Illness (Table ronde mondiale des affaires et de l'économie sur la toxicomanie et la maladie mentale), créée en 1998 à titre « d'instrument d'information, d'analyse et d'idées sur les liens entre l'entreprise, l'économie, la santé mentale et le travail »[188]. La Table ronde a sensibilisé les employeurs à la question de la maladie mentale et favorisé la mise en commun de pratiques exemplaires. Des solutions efficaces et de nouvelles approches en ont déjà résulté et sont mises en œuvre dans le secteur privé afin de promouvoir le mieux-être au travail.

Le gouvernement fédéral, en tant qu'employeur, aurait tout intérêt à établir des liens avec le secteur privé pour découvrir des façons de faire applicables dans son propre milieu de travail, notamment pour éliminer l'opprobre qui entoure la maladie mentale.

Le Comité recommande par conséquent :

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186 15 février 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/05eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

187 Agence de santé publique du Canada, communiqué de presse, « Nomination de Michael Wilson au poste de conseiller spécial du ministre pour la santé mentale », 4 février 2005.

188 Global Business and Economic Roundtable on Addiction and Mental Health, http://www.mentalhealthroundtable.ca/about_us.html.

84	**Que le gouvernement fédéral s'inspire du modèle établi par la Global Business and Economic Roundtable on Addiction and Mental Illness pour coordonner ses politiques, programmes et services interministériels relatifs à la maladie mentale.** **Que le gouvernement fédéral, en tant qu'employeur, fasse alliance avec d'autres secteurs et ordres de gouvernement, et notamment avec la Global Business and Economic Roundtable on Addiction and Mental Illness, pour stimuler et faciliter la mise en commun de pratiques exemplaires pouvant favoriser le mieux-être en milieu de travail et une meilleure santé mentale chez les employés.** **Qu'en élaborant ses stratégies de promotion de la santé mentale en milieu de travail, le gouvernement fédéral mette l'accent sur des mesures pouvant réduire et, avec le temps, éliminer la stigmatisation de la maladie mentale.**

Le Comité estime essentiel que les programmes fassent l'objet d'une évaluation périodique pour voir s'ils atteignent leurs objectifs et répondent à des besoins réels. Pour déterminer l'efficacité des mesures conçues afin d'aider les employés du gouvernement à faire face à la maladie mentale, le gouvernement fédéral ne peut pas se contenter de dresser la liste des programmes et politiques en place.

Par conséquent, le Comité recommande :

85	**Que l'Agence de gestion des ressources humaines de la fonction publique procède à l'évaluation annuelle des politiques, programmes et activités mises en place par le gouvernement fédéral afin de promouvoir la santé mentale dans la fonction publique.** **Que ces évaluations se fondent sur des indicateurs de rendement clairs et notamment sur des sondages d'opinion servant à déterminer le degré de satisfaction des employés.** **Que les évaluations servent de base à la modification des politiques, des programmes et des activités afin qu'ils soient mieux adaptés aux besoins des employés.** **Que les résultats de ces évaluations, et les modifications qui en ont résulté, fassent l'objet d'un rapport annuel au Parlement à compter de 2008.**

13.8 VERS UNE STRATÉGIE GLOBALE VISANT LA CLIENTÈLE FÉDÉRALE

La clientèle fédérale, comme l'ensemble de la population canadienne, a besoin d'un éventail de programmes et de services pour conserver ou retrouver une bonne santé mentale. Comme nous l'avons vu tout au long du présent chapitre, chaque groupe de clients fédéraux fait face à des problèmes différents et chacun a besoin de solutions adaptées à ses besoins. Par exemple, les déterminants fondamentaux de la santé que sont le logement et le soutien communautaire sont des facteurs cruciaux sur lesquels il faut se pencher dans le cas des anciens combattants comme dans le cas des Premières nations et des Inuits. Les employés de la fonction publique, quant à eux, ont surtout besoin qu'on s'intéresse à leurs conditions de travail et aux mesures d'adaptation à fournir aux personnes atteintes de maladie mentale.

Le Comité ne comprend pas pourquoi le gouvernement fédéral n'a jamais élaboré une stratégie globale claire et cohérente pour répondre aux besoins des clients qui sont sous sa responsabilité. Le Comité estime qu'une telle stratégie globale est essentielle pour améliorer la santé de tous les groupes visés tout en reconnaissant le caractère distinct des besoins de chacun.

Il importe aussi de réitérer que le gouvernement fédéral est responsable de ces diverses clientèles pendant des durées variables. Certains, comme les Premières nations et les Inuits, sont clients à vie. Les anciens combattants demandent en général accès aux services de santé mentale relativement tard dans leur vie. Les réfugiés, pour leur part, ne sont parfois sous responsabilité fédérale que pendant les premiers mois de leur séjour au Canada, après quoi ils passent sous responsabilité provinciale, et les délinquants sous responsabilité fédérale sont à la charge du gouvernement fédéral jusqu'à leur remise en liberté. D'autres, comme les membres de la GRC, les membres des Forces canadiennes et les employés de la fonction publique, relèvent du gouvernement fédéral tant qu'ils restent au service de leur employeur.

Le Comité comprend que ces situations très variées posent un défi au gouvernement fédéral qui doit mettre en place les programmes et services de santé mentale, de maladie mentale et de toxicomanie nécessaires à tous ces clients. Toutefois, le Comité ne comprend pas pourquoi le gouvernement fédéral n'a jamais élaboré une stratégie globale claire et cohérente pour répondre aux besoins des clients qui sont sous sa responsabilité. Le Comité estime qu'une telle stratégie globale est essentielle pour améliorer la santé de tous les groupes visés tout en reconnaissant le caractère distinct des besoins de chacun.

Par conséquent, le Comité recommande :

86	**Que le gouvernement fédéral élabore une stratégie de santé mentale applicable à l'ensemble de la clientèle fédérale, tout en tenant compte des besoins particuliers de chaque groupe.** **Que cette stratégie fixe des objectifs, notamment un calendrier de mise en œuvre et d'évaluation subséquente.**

Que la stratégie ait pour objectif de faire du gouvernement fédéral un employeur modèle et un fournisseur modèle de service à ses divers clients.

13.8.1 Approche axée sur les déterminants de la santé

Le gouvernement fédéral a toujours été un chef de file dans l'élaboration des grands principes de santé publique, depuis la parution du célèbre Rapport Lalonde. Le Comité estime que le gouvernement a l'occasion et l'obligation morale d'appliquer ces grands principes à sa propre clientèle.

En 2004, le gouvernement fédéral a déclaré être le cinquième plus grand fournisseur de services de santé à la population canadienne, desservant environ 950 000 personnes à un coût annuel de 3,4 milliards de dollars [189]. Le Comité estime que l'engagement du gouvernement fédéral à l'égard de la santé mentale doit s'étendre aux déterminants de la santé, lesquels vont bien au-delà des seuls services de santé, étant donné les nombreux facteurs à l'œuvre selon le groupe de clients. Ces facteurs sont, notamment : la salubrité du logement, l'accès au revenu, la présence d'un réseau d'entraide, l'accès à l'éducation et la possibilité de trouver du travail.

Le Comité estime que le gouvernement a l'occasion et l'obligation morale d'appliquer ces grands principes de santé publique à sa propre clientèle.

Étant donné ses nombreuses responsabilités dans la prestation de services de santé mentale, le gouvernement fédéral doit prêcher par l'exemple.

Étant donné ses nombreuses responsabilités dans la prestation de services de santé mentale, le gouvernement fédéral doit prêcher par l'exemple, notamment en misant sur la promotion de la santé mentale et la prévention de la maladie mentale et des toxicomanies. Par la collaboration interministérielle et un travail soutenu auprès de ses divers groupes de clients, le gouvernement fédéral pourrait devenir un modèle pour l'ensemble du pays en ce qui concerne l'élaboration et la mise en œuvre de stratégies de santé publique.

Par conséquent, le Comité recommande :

87 **Que la stratégie de santé mentale que le gouvernement fédéral mettra au point s'inscrive dans une optique de santé publique et mise sur les facteurs déterminants de la santé mentale, et plus particulièrement sur les facteurs économiques, éducationnels, professionnels et sociaux qui ont une incidence sur la santé mentale de tous les clients fédéraux.**

[189] Santé Canada, *Les Canadiens en santé : Rapport fédéral sur les indicateurs comparables de la santé,* 2004, http://www.hc-sc.gc.ca/hcs-sss/pubs/care-soins/2002-fed-comp-indicat/2002-health-sante4_f.html.

Que le gouvernement fédéral fasse rapport au Parlement en 2008 de ce qu'il entend mettre en œuvre comme stratégie de santé publique destinée aux clients fédéraux.

13.8.2 Activités visant à éliminer la stigmatisation

Au chapitre 16, le Comité recommande que la Commission canadienne de la santé mentale amorce une campagne sur dix ans visant à combattre la stigmatisation qui frappe actuellement les personnes atteintes de maladie mentale. La présence d'un représentant du fédéral au Conseil de la Commission permettra au gouvernement de faire entendre son point de vue dans cette campagne pancanadienne contre la stigmatisation. Mais le Comité estime que le gouvernement fédéral doit prendre l'initiative de la lutte contre la stigmatisation parmi ses groupes de clients.

Le Comité recommande :

88	**Que le gouvernement fédéral élabore et mette immédiatement sur pied une campagne de lutte contre la stigmatisation pour aider tous ses groupes de clients.**

13.8.3 Voies de recours

Le Comité a recommandé que les ministères fédéraux responsables créent des instances semblables pour d'autres groupes de clients fédéraux, comme les anciens combattants, les Premières nations et les Inuits, les immigrants et les réfugiés qui actuellement n'ont aucun recours de ce genre.

Comme nous l'avons dit plus haut dans ce chapitre, plusieurs ministères fédéraux ont, depuis quelques décennies, créé chacun un organisme indépendant et impartial chargé d'examiner des questions de toutes sortes mettant en cause leurs clients. Certaines de ces instances sont habilitées à accueillir des griefs relatifs à la santé mentale. Par exemple, l'Enquêteur correctionnel et le Comité externe d'examen de la GRC sont mandatés par la loi pour étudier des questions de santé mentale, de même que d'autres questions d'intérêt pour les membres de leurs groupes respectifs; ils font rapport au ministre compétent et recommandent des interventions. D'autres, comme l'Ombudsman des Forces canadiennes et le conseiller spécial en santé mentale du gouvernement fédéral, n'ont pas de mandat législatif.

Le Comité a recommandé que les ministères fédéraux responsables créent des instances semblables pour d'autres groupes de clients fédéraux, comme les anciens combattants, les Premières nations et les Inuits, les immigrants et les réfugiés qui actuellement n'ont aucun recours de ce genre.

Dans le contexte d'une stratégie fédérale globale, le Comité estime important que ces instances soient liées entre elles afin d'agir à titre d'ombudsman fédéral sur les questions ayant trait à la santé mentale. Il envisage une instance habilitée à faire enquête, à résoudre des

griefs individuels, à faire des recommandations, à signaler des zones de problème systémiques, et à assurer le suivi des dossiers de clients issus de tous les groupes fédéraux.

Le Comité recommande :

89	**Que le gouvernement fédéral crée un mécanisme central de coordination des activités d'élaboration et de mise en œuvre des politiques, programmes et services relatifs à la santé mentale dans l'ensemble de ses ministères et organismes.** **Que cette entité fédérale travaille en collaboration avec l'Enquêteur correctionnel, l'Ombudsman des Forces canadiennes et le Comité externe d'examen de la GRC et les autres instances semblables qui seront créées par les ministères pour faire en sorte que les besoins de chaque groupe client soient satisfaits.** **Que cette entité fédérale coordonne et supervise les activités de ces diverses instances dans leur travail d'enquête et de résolution des préoccupations soulevées par les groupes de clients fédéraux concernant des services de santé mentale qui leur sont offerts.** **Que cette entité fédérale fasse un rapport annuel au Parlement.**

13.8.4 Évaluation de l'assurance fédérale en santé mentale

Le gouvernement fédéral est donc entièrement responsable des programmes et services médicaux offerts à trois groupes de clients : les Forces canadiennes, la GRC et les délinquants sous responsabilité fédérale. Les autres — les Premières nations et les Inuits, les anciens combattants, les immigrants et réfugiés et les fonctionnaires fédéraux — relèvent du gouvernement fédéral à des degrés importants mais variables. Le gouvernement fédéral estime que les provinces doivent assumer la plus grande partie de la responsabilité des services offerts à ces derniers groupes de clients, comme elles le font pour l'ensemble de la population canadienne.

Les conditions établies par la *Loi canadienne sur la santé* (*LCS*) auxquelles les régimes provinciaux d'assurance-maladie doivent satisfaire pour recevoir les transferts fédéraux excluent expressément certains groupes de clients sous responsabilité fédérale. Sous « services de santé assurés », la *LCS* exclut les « services de santé auxquels une personne a droit ou est admissible en vertu d'une autre loi fédérale ». Elle exclut aussi les « hôpitaux ou institutions destinés principalement aux personnes souffrant de troubles mentaux ». Plus précisément, la Loi stipule que les « assurés » auxquels sont offerts les services couverts par les régimes provinciaux d'assurance-maladie sont les habitants d'une province autres que :

a) des membres des Forces canadiennes,

b) des membres de la Gendarmerie royale du Canada nommés à un grade,

c) des personnes purgeant une peine d'emprisonnement dans un pénitencier, au sens de la Partie I de la *Loi sur le système correctionnel et la mise en liberté sous condition*[190].

Le gouvernement fédéral est donc entièrement responsable des programmes et services médicaux offerts à trois groupes de clients : les Forces canadiennes, la GRC et les délinquants sous responsabilité fédérale. Les autres — les Premières nations et les Inuits, les anciens combattants, les immigrants et réfugiés et les fonctionnaires fédéraux — relèvent du gouvernement fédéral à des degrés importants mais variables.

Le gouvernement fédéral estime que les provinces doivent assumer la plus grande partie de la responsabilité des services offerts à ces derniers groupes de clients, comme elles le font pour l'ensemble de la population canadienne. Comme Ian Potter l'explique, en faisant allusion aux Premières nations et aux Inuits :

Il reste cependant que tous les groupes de clients ont des besoins de santé mentale qui ne sont pas couverts par les régimes provinciaux d'assurance-maladie. Pour répondre à ces besoins, le gouvernement fédéral a trouvé une solution distincte pour chaque groupe.

> *[L]es services qui sont assurés par la Loi canadienne sur la santé, ce que nous appelons les services assurés, sont fournis par la province. Si le gouvernement fédéral s'occupe de la prestation de services médicaux ou hospitaliers, nous demandons le remboursement de ces services à la province*[191].

Il reste cependant que tous les groupes de clients ont des besoins de santé mentale qui ne sont pas couverts par les régimes provinciaux d'assurance-maladie. Pour répondre à ces besoins, le gouvernement fédéral a trouvé une solution distincte pour chaque groupe. Les Forces canadiennes, la GRC et Service correctionnel Canada font entrer les soins de santé non assurés et les traitements pour maladie mentale sous la rubrique des nécessités opérationnelles; les Premières nations et les Inuits ont accès au Programme des services de santé non assurés; les anciens combattants ont leur Programme de soins de santé; les réfugiés ont le Programme fédéral de santé intérimaire; et les fonctionnaires ont le Régime de soins de santé de la fonction publique. En plus, il existe toute une gamme de régimes d'assurance-invalidité.

Le Comité a été étonné d'apprendre qu'il y avait un aussi grand nombre de programmes à la disposition des clients fédéraux, et qu'ils échappaient à pratiquement toute obligation de compte rendu ou d'évaluation de fonctionnement.

George Lucki, président, Alberta Alliance on Mental Illness and Mental Health, indique que les efforts du fédéral pour couvrir les besoins additionnels de ses clients sont caractérisés par un manque de coordination avec les provinces :

> *Le gouvernement fédéral est un important acheteur d'avantages non assurés qui fournissent à ceux qui travaillent pour le gouvernement*

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190 *Loi canadienne sur la santé*, ch. C-6, art. 2 — Définitions, http://lois.justice.gc.ca/fr/C-6/183585.html#rid-183588.

191 20 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/13eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

fédéral ou ceux dont les soins de santé sont une responsabilité fédérale des soins de santé mentale qui ne sont pas offerts à l'ensemble de la population canadienne.

Ces services eux-mêmes sont souvent mal coordonnés, avec les autres services de santé offerts par les autorités provinciales. Nous pensons que ces programmes doivent être révisés au complet pour s'assurer qu'ils reflètent les pratiques exemplaires et répondent aux besoins de santé mentale de ceux qu'ils desservent[192].

Le Comité a été étonné d'apprendre qu'il y avait un aussi grand nombre de programmes à la disposition des clients fédéraux, et qu'ils échappaient à pratiquement toute obligation de compte rendu ou d'évaluation de fonctionnement. Le Programme des services de santé non assurés des Premières nations et des Inuits est le seul pour lequel un rapport exhaustif doit être déposé au Parlement tous les ans. Le Comité a eu vent des autres programmes par des allusions faites ici et là, mais n'en a reçu aucune description officielle et n'a eu accès à aucun rapport.

Par conséquent, le Comité recommande :

90	**Que le gouvernement fédéral entreprenne immédiatement une évaluation des tous les régimes d'assurance mis à la disposition de ses clients afin d'en déterminer l'efficacité et l'applicabilité.** **Que cette évaluation comprenne une appréciation comparative des avantages, de la protection en matière de santé mentale, de maladie mentale et de toxicomanie, des frais administratifs, et des résultats obtenus dans le cas de chaque régime d'assurance.** **Que cette évaluation des régimes d'assurance fasse l'objet d'un rapport déposé au Parlement en 2008.**

13.8.5 Coordination et rapport au Parlement

En 2005, le ministre de la Santé a créé un groupe de travail interministériel chargé de trouver de nouveaux moyens d'intégrer les services et les pratiques des divers ministères fédéraux qui interviennent dans le secteur de la santé mentale. Ce groupe de travail, formé de représentants issus de 20 ministères et organismes, est piloté conjointement par Santé Canada et l'Agence de santé

Malgré l'existence, dans de nombreux ministères et organismes du gouvernement fédéral, de politiques, de programmes et d'activités visant à répondre aux besoins de santé mentale des divers groupes de clients, le Comité n'a trouvé aucune entité centrale au courant de l'ensemble de ces activités, aucune tribune permettant la mise en commun de solutions ou de pratiques exemplaires, et aucune source centralisée d'information sur les détails des programmes, leur coût ou leur rendement.

[192] 9 juin 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/21evb-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

publique du Canada. Il a pour mandat d'étudier les activités fédérales et d'en accroître la cohésion dans les secteurs de la promotion et de la préservation de la santé mentale, la prestation de services et l'élaboration de politiques. Le Comité estime qu'il s'agit là d'un important premier pas dans la bonne direction, mais considère que le gouvernement fédéral doit aller beaucoup plus loin dans ses efforts pour coordonner ses divers programmes et services.

Malgré l'existence, dans de nombreux ministères et organismes du gouvernement fédéral, de politiques, de programmes et d'activités visant à répondre aux besoins de santé mentale des divers groupes de clients, le Comité n'a trouvé aucune entité centrale au courant de l'ensemble de ces activités, aucune tribune permettant la mise en commun de solutions ou de pratiques exemplaires, et aucune source centralisée d'information sur les détails des programmes, leur coût ou leur rendement. Mais surtout, personne ne semble avoir un tableau complet de l'état de santé mentale de la clientèle fédérale ni de la gamme de services offerte dans ce domaine. Ce manque de coordination ne peut qu'entraîner chevauchements de responsabilités, double emploi et gaspillage de ressources.

Le Comité estime aussi qu'il est essentiel pour le gouvernement fédéral de faire régulièrement rapport au Parlement de ses programmes et services de santé mentale.

Le Comité constate que la *Loi canadienne sur la santé* charge les provinces et les territoires de produire un rapport annuel faisant état de leurs services médicaux, hospitaliers et autres, mais que le gouvernement fédéral, lui, ne fait aucun rapport annuel, global et coordonné, pour rendre compte au Parlement de ses activités dans le secteur de la santé et des services de santé.

Le Comité estime aussi qu'il est essentiel pour le gouvernement fédéral de faire régulièrement rapport au Parlement de ses programmes et services de santé mentale. À l'heure actuelle, on demande aux parlementaires de prendre des décisions en matière de santé mentale, de maladie mentale et de toxicomanie sans avoir accès à toute l'information nécessaire. Par exemple, lorsque la Vérificatrice générale du Canada a fait rapport, en 2004 sur les programmes fédéraux de prestations pharmaceutiques, elle a constaté que le gouvernement fédéral possédait des données à jour et très factuelles sur la consommation de médicaments, mais que ces données n'étaient pas analysées de façon systématique, ni communiquées aux professionnels de la santé pour les aider à répondre aux besoins de santé de leurs clients [193].

Les ministères donnent actuellement certains détails dans leurs plans et priorités et leurs rapports de rendement, mais aucun rapport global portant sur l'ensemble des programmes de santé fédéraux n'est déposé au Parlement. Le Comité constate que la *Loi canadienne sur la santé* charge les provinces et les territoires de produire un rapport annuel faisant état de leurs services médicaux, hospitaliers et autres, mais que le gouvernement fédéral, lui, ne fait aucun rapport annuel, global et coordonné, pour rendre compte au Parlement de ses activités dans le secteur de la santé et des services de santé.

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[193] Bureau du vérificateur général du Canada, *La gestion des programmes fédéraux de prestations pharmaceutiques*, ch. 4, novembre 2004, http://www.oag-bvg.gc.ca/domino/rapports.nsf/html/20041104cf.html.

Le Comité a déjà demandé que certains ministères, qui ont un rôle important à jouer en santé mentale auprès de groupes particuliers de clients canadiens, produisent des rapports. Mais il faut envisager ces rapports dans une perspective de coordination pour que le Parlement dispose de l'information globale dont il a besoin pour rendre des décisions législatives et budgétaires éclairées qui servent réellement les intérêts des clients.

Par conséquent, le Comité recommande :

91	**Que tous les ministères fédéraux qui ont la responsabilité directe d'offrir des programmes et services à certains groupes de clients – notamment les Premières nations et les Inuits, les délinquants sous responsabilité fédérale, les immigrants et les réfugiés, les anciens combattants, les Forces canadiennes, la GRC et les employés de la fonction publique fédérale – produisent un rapport annuel qui décrit la responsabilité fédérale et les programmes et services fédéraux et qui indique dans quelle mesure ceux-ci répondent aux besoins de santé mentale des clients visés.** **Que ce rapport comprenne un relevé annuel de leurs programmes et services respectifs ainsi qu'une comparaison sur trois ans.** **Que ce relevé décrive clairement, pour chaque programme ou service et par exercice financier, les critères d'admissibilité, le nombre de clients desservis, les budgets accordés et les sommes dépensées, et présente une évaluation des résultats obtenus par rapport aux facteurs déterminants de la santé mentale.** **Que ce relevé soit déposé au Parlement tous les ans à compter de 2008.**

14.1 INTRODUCTION

> *Les peuples autochtones, le continuum de la santé, c'est le bien-être et non pas la maladie. La santé mentale des Autochtones est relationnelle, parce que la force et la sécurité sont tributaires de la famille et de la collectivité. En plus de partager les traditions en matière de guérison, les collectivités autochtones sont liées par un concept de bien-être selon lequel l'esprit, le corps et l'âme sont interreliés. —Debbie Dedam-Montour*[194]

Pour beaucoup de peuples autochtones, le continuum du bien-être est gravement perturbé. Chaque jour, particuliers et collectivités doivent surmonter des difficultés, que ce soit dans leurs conditions de vie matérielles, dans leur milieu social ou sur le plan psychologique. Et, pour beaucoup, chômage chronique, violence, toxicomanie et suicide en sont les conséquences. Le Comité ne peut donc que conclure que la façon dont le Canada a toujours traité ses citoyens autochtones est une honte nationale.

Le Comité ne peut donc que conclure que la façon dont le Canada a toujours traité ses citoyens autochtones est une honte nationale.

Malgré les multiples rapports publiés sur la question et les importantes ressources humaines et financières qui y ont été consacrées, la santé mentale des peuples autochtones continue d'être gravement menacée. La santé mentale des peuples autochtones se situe à l'extrémité inférieure du continuum.

Il faut toutefois se garder de parler des peuples autochtones comme d'une entité homogène. La *Loi constitutionnelle de 1982* reconnaît trois groupes de peuples autochtones, qu'elle définit comme « les Indiens, les Inuit et les Métis du Canada »[195]. Compte tenu de la diversité qui existe entre chacun et au sein même de ces groupes, des témoins ont fait observer que :

> *De nombreux changements doivent être apportés et de nombreuses initiatives doivent être entreprises afin que le dossier de la santé mentale des peuples autochtones progresse de façon significative. Les politiques, programmes et procédures adoptés par le gouvernement doivent respecter et inclure tous les concepts des Premières nations, des Métis et des Inuits au sujet de la santé et de la guérison. —Bernice Downey*[196]

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194 20 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/27evb-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

195 Dans le présent chapitre, les peuples autochtones désignent les personnes qui se reconnaissent comme membres des Premières nations, des Indiens inscrits, des Indiens non inscrits, des Métis ou des Inuits.

196 21 avril 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/13evb-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

Le Comité accepte difficilement que globalement, malgré les multiples rapports publiés sur la question et les importantes ressources humaines et financières qui y ont été consacrées, la santé mentale des peuples autochtones continue d'être gravement menacée. Si l'on prend les taux de suicide et de toxicomanie comme critères, la santé mentale des peuples autochtones se situe à l'extrémité inférieure du continuum. Des témoins se sont dits découragés devant la fréquence des consultations gouvernementales combinée à l'absence de gestes donnant des résultats. Selon l'un d'entre eux :

> *La réalité, c'est que ce processus ne va pas très loin. Nos commentaires et nos suggestions sont bien étayés, mais il reste à voir si on y donne suite.*
> *—Lorraine Boucher*[197]

Le Comité reconnaît qu'il ne peut en un seul chapitre revoir le sort déplorable que connaissent depuis longtemps les peuples autochtones du Canada. Il compte plutôt se faire l'écho de tous ceux qui ont pris le temps de lui faire connaître leur point de vue. Le Comité s'est fait dire que les facteurs qui encouragent le bien-être des peuples autochtones — appui à la famille et à la collectivité, débouchés économiques, sécurité sociale et physique, etc. — sont ceux qui, s'ils font défaut, créent la nécessité d'une guérison. On lui a également dit que, si les peuples autochtones pouvaient être les maîtres de leur santé individuelle et collective et en assumer le contrôle, une bonne partie de leurs problèmes médicaux actuels n'existeraient tout simplement pas.

14.1.1 Un comité consultatif national des Autochtones

Le Comité tient à faire en sorte que soient mis sur pied des mécanismes nationaux permanents permettant d'obtenir l'avis des peuples autochtones et d'y donner suite par des mesures concrètes. Dans sa recommandation proposant de créer une Commission canadienne de la santé mentale (voir le Chapitre 16), le Comité décrit trois mesures expressément conçues pour garantir qu'il en soit ainsi. Premièrement, l'une des personnes désignées par les gouvernements sera un représentant des gouvernements territoriaux et sera donc en mesure de faire connaître les préoccupations propres aux peuples autochtones du Nord. Deuxièmement, le rapport de la Commission devra préciser qu'il devra y avoir, parmi les membres de son conseil d'administration ne représentant pas un gouvernement, des personnes connaissant et comprenant les problèmes propres aux Canadiens d'ascendance autochtone. Troisièmement, l'un des deux comités consultatifs que la Commission instituera devra être un comité consultatif autochtone.

Le Comité tient à faire en sorte que soient mis sur pied des mécanismes nationaux permanents permettant d'obtenir l'avis des peuples autochtones et d'y donner suite par des mesures concrètes.

Dans la structure de la Commission de la santé mentale, le comité consultatif autochtone tiendrait la même place et aurait le même poids que le comité consultatif représentant les gouvernements provinciaux et territoriaux.

[197] 20 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/27evb-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

Le Comité reconnaît qu'un rapport tel que celui-ci — portant sur les maladies mentales, les toxicomanies et leur traitement — ne peut embrasser l'ensemble des impondérables constitutionnels, d'orientation stratégique et de gouvernance qui ont une incidence réelle sur la santé et le bien-être des peuples autochtones, mais il a l'intime conviction que les mesures qu'il y recommande de prendre dans l'espoir d'améliorer la santé mentale chez les peuples autochtones pourraient ouvrir la voie à des initiatives plus ambitieuses.

Sous ce rapport, il convient de noter qu'en plus du comité consultatif autochtone, la Commission de la santé mentale ne devra créer qu'un seul autre comité consultatif et que ce comité sera composé de représentants des gouvernements provinciaux et territoriaux. Ainsi, dans la structure de la Commission de la santé mentale, le comité consultatif autochtone tiendrait la même place et aurait le même poids que le comité consultatif représentant les gouvernements provinciaux et territoriaux.

Aux yeux du Comité, le comité consultatif autochtone est un élément essentiel d'une entreprise plus vaste (et plus durable) visant à améliorer de façon marquée la santé mentale et le bien-être de tous les peuples autochtones. Ce comité jouera à notre avis un rôle de coordination essentiel à l'élaboration d'une stratégie expressément axée sur la protection de la santé mentale et basée sur les façons de faire distinctes qui s'imposent dès qu'on traite avec une collectivité autochtone. Comme il ressort clairement des sections qui suivent, cette stratégie devra répondre aux appels répétés des peuples autochtones, qui demandent depuis longtemps qu'on délègue la compétence en la matière et le contrôle des programmes et services aux collectivités, qu'on adapte ces programmes et services en fonction de leurs cultures et qu'on leur assure un accès équitable aux programmes et aux services de santé mentale.

Ce comité jouera à notre avis un rôle de coordination essentiel à l'élaboration d'une stratégie expressément axée sur la protection de la santé mentale et basée sur les façons de faire distinctes qui s'imposent dès qu'on traite avec une collectivité autochtone.

Le Comité croit également que les recommandations qu'il fait dans le présent rapport — en vue d'obtenir que les peuples autochtones participent pleinement à la conception et à la prestation de services de santé mentale et de services d'appui améliorés — sont parfaitement compatibles avec le principe de la prestation des soins de santé mentale dans la collectivité, principe qu'il propose d'ailleurs d'appliquer à l'ensemble de la population. Il espère donc que le comité consultatif autochtone réussira à avoir au sein de la Commission de la santé mentale un dialogue fructueux grâce auquel les Canadiens non autochtones pourront s'enrichir de l'expérience et des traditions des Canadiens autochtones dans le domaine de la protection de la santé mentale et du bien-être.

Le Comité insiste donc sur la recommandation faite au Chapitre 16, voulant :

Que la Commission canadienne de la santé mentale (voir le Chapitre 16) établisse un Comité consultatif des Autochtones composé de représentants des communautés autochtones, dont elle établira la composition en consultation avec des organismes autochtones de manière à représenter les Premières nations, les Inuits et les Métis et refléter globalement la répartition géographique des collectivités autochtones dans le pays.

14.2 LE BIEN-ÊTRE COMME OBJECTIF

Des témoins représentant l'ensemble des peuples autochtones ont déclaré avec insistance qu'il fallait moins s'attacher à la maladie mentale et plus au bien-être mental. Ils ont prôné une approche holistique et globale portant sur tous les déterminants de la santé.

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Valerie Gideon, directrice du Secrétariat à la santé et au développement social, Assemblée des Premières nations, a prôné une stratégie holistique et globale de bien-être des Premières nations :

> *La santé mentale et la prévention du suicide seront certainement les points essentiels de cette stratégie. La stratégie visera une approche holistique des mécanismes permettant aux collectivités la flexibilité d'allouer des ressources aux priorités et d'établir des liens avec certains déterminants de la santé tels que l'enseignement, le logement et les questions sociales et environnementales*[198].

Les Inuits recherchent également une approche qui tienne compte de leur situation particulière. Selon Onalee Randell, directrice de la santé, Inuit Tapiriit Kanatami, les Inuits ont besoin :

> *..[d']une gamme continue de services pertinents sur le plan culturel et qui engloberait le savoir et les pratiques traditionnelles de leur collectivité natale ou, du moins, de leur région natale. Des services d'aide aux personnes et à leurs familles. Des services qui éliminent les barrières et qui prennent en compte les déterminants médicaux et non médicaux de la*

[198] 20 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/27eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

> *santé mentale, y compris dans les domaines de l'économie, de l'environnement, du logement et de l'éducation*[199].

Bien que peu d'organismes métis aient participé directement aux délibérations du Comité, Bernice Downey, directrice administrative, Organisation nationale de la santé autochtone, a présenté le point de vue de l'unité sanitaire métisse. Elle a insisté sur le fait que, pour élaborer un plan exhaustif traitant de la santé mentale, la maladie mentale et la toxicomanie chez les Canadiens autochtones, y compris les Métis :

> *...le gouvernement doit reconnaître et respecter non seulement les droits constitutionnels des Métis, mais également les concepts de santé et de bien-être qui sont particuliers aux Métis*[200].

14.2.1 La santé mentale plutôt que la maladie mentale

Envisager les choses sous l'angle de la maladie mentale constitue, pour la plupart des témoins entendus, une approche négative et stigmatisante, si bien que personne n'ose soulever de questions précises sur le sujet. Pour certains, comme Arnold Devlin, Dilico Ojibway Child and Family Services :

Selon des témoins, il faudrait adopter une approche holistique qui réponde aux besoins spirituels, émotionnels, mentaux et physiques des individus qui se trouvent aux prises avec une réalité sociale, culturelle, économique et politique particulière.

> *Il importe de faire une distinction entre les troubles mentaux et la maladie mentale. Il n'y a pas de raison de s'attendre à ce que la maladie mentale soit plus fréquente au sein de la collectivité autochtone qu'au sein de la population générale, et je n'en vois pas de preuve. C'est vrai que les Autochtones sont aux prises avec plus de troubles mentaux. C'est ce dont il est question. Il existe une très grande différence entre les deux*[201].

Il a insisté sur le fait que, pour de nombreux peuples autochtones, les manifestations externes de leur état peuvent être perçues comme « de la détresse mentale plutôt que comme une maladie. La détresse mentale peut prendre la forme d'un épisode particulier qui dure un certain temps, mais je ne le qualifierais pas de maladie mentale »[202].

Le Comité a appris que les peuples autochtones ne sont pas plus prédisposés que d'autres à certaines maladies mentales, mais que des personnes peuvent être profondément incapables de fonctionner dans la société canadienne, une incapacité trop souvent exprimée sous forme

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199 20 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/27eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

200 21 avril 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/13evb-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

201 20 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/27evb-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

202 20 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/27evb-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

de dépression, de suicide et de toxicomanie. Pour Elsie Bastien, coordonnatrice des liaisons avec les Autochtones, Alberta Mental Health Board :

> *La santé mentale est une préoccupation pour les Autochtones non pas parce que les Autochtones ont des taux plus élevés de maladie mentale aiguë telle que la schizophrénie, mais parce qu'un bon nombre d'entre eux ont des symptômes de troubles mentaux de faible niveau, dont les effets sont pourtant débilitants. Les indicateurs de ce fait sont les taux élevés d'alcoolisme, de toxicomanie, de suicides, d'accidents, de violence, ainsi que les échecs scolaires, le chômage et l'incarcération*[203].

Pour prévenir ou pallier de tels effets, il faudrait, selon des témoins, adopter une approche holistique qui réponde aux besoins spirituels, émotionnels, mentaux et physiques des individus qui se trouvent aux prises avec une réalité sociale, culturelle, économique et politique particulière. Au dire de Sheila Levy, présidente, Nunavut Kamatsiaqtut Help Line :

> *La pauvreté, la criminalité, la violence, les toxicomanies, toutes les catégories d'abus, les logements bondés, l'aliénation, l'abandon et le suicide ont tous rapport avec le bien-être mental et physique. Cette interrelation des enjeux de la santé mentale est souvent négligée*[204].

14. 3 LE BIEN-ÊTRE PAR LA GUÉRISON

Les témoins se sont dits fortement désireux d'aller de l'avant à l'aide des pratiques de guérison propres à leur culture traditionnelle.

Pour en arriver au bien-être émotionnel souhaité par et pour les individus, les familles et les collectivités de tous les peuples autochtones, il faut une guérison. Conscients de l'incidence qu'ont encore les injustices passées, les témoins se sont dit fortement désireux d'aller de l'avant à l'aide des pratiques de guérison propres à leur culture traditionnelle.

Bernice Downey a expliqué la perspective métisse en matière de guérison :

> *...Cela comprend notamment la prestation de services en langue autochtone et l'inclusion des connaissances et pratiques de guérison traditionnelles*[205].

Jennifer Dickson, directrice exécutive, Pauktutit Inuit Women's Association, a demandé :

> *...un centre de guérison dans chaque collectivité éloignée de l'Arctique canadien. Il doit y avoir des travailleurs bien formés en santé mentale.*

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[203] 9 juin 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/21evb-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

[204] 20 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/27evb-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

[205] 21 avril 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/13evb-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

Ces centres pourraient fournir des endroits où les aînés, les adultes, les jeunes et les organismes pourraient s'écouter véritablement l'un l'autre et participer à des interventions et à des méthodes de guérison traditionnelles[206].

Bill Mussell, président, Native Mental Health Association, a affirmé avec insistance que, si le peuple des Premières nations avait la possibilité de comprendre son passé par des processus de guérison, il adopterait des façons plus saines de faire face à la réalité :

Quand on pense au deuil, à la guérison et aux effets des traumatismes, il y a une façon d'aider les gens à vivre ce qui s'est passé de manière à ce qu'ils puissent continuer de grandir et de se développer. Ils doivent vivre leurs expériences. Ce processus peut être fructueux s'il est réalisé avec des gens qui les aiment, capables de leur offrir la protection nécessaire pour qu'ils puissent se mettre en contact avec la dynamique de leur vie[207]

14.3.1 La nécessité de guérir

La Commission royale sur les peuples autochtones a estimé que, parmi les forces destructrices qui continuent de saper la confiance et la santé globale des peuples autochtones, il convient de citer, outre les facteurs socio-économiques et situationnels, la perte de territoires et de contrôle des conditions de vie, la suppression du système de croyance et de spiritualité, l'affaiblissement des institutions sociales et politiques et la discrimination raciale[208].

Sur le million d'Autochtones vivant actuellement au Canada, plus d'un tiers a été touché par l'expérience des pensionnats, soit directement pour avoir fréquenté un pensionnat, soit indirectement pour avoir fait partie de la famille ou de la collectivité associée aux survivants

Pour bien comprendre la nécessité de la guérison, Tarry Hewitt, coordonnateur de projet, Aboriginal Survivors for Healing, a rappelé aux membres du Comité qu' :

…il est essentiel de comprendre le contexte historique. En revisitant l'impact de la colonisation et, en particulier, le legs du système de pensionnats, il semble que nous revisitons un passé que d'autres rapports produits devant ce comité ont déjà traité. Mais il me semble important de relier les points pour comprendre le chemin parcouru, le chemin qui reste à faire et ce qu'il faut restaurer et utiliser du passé[209].

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206 20 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/13evb-f.htm?Language=F&Parl=38&Ses=1&comm_id=47

207 20 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/27evb-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

208 Commission royale sur les peuples autochtones, « Choisir la vie : un rapport spécial sur le suicide chez les Autochtones » (1995)

209 16 juin 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/22evc-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

Selon Gail Valaskakis, directrice de la recherche, Fondation autochtone de guérison, il faudra plusieurs générations pour effacer le traumatisme subi par les Autochtones qui sont allés dans des pensionnats :

> *Ils concernent les pertes subies par ceux qui ont fréquenté les pensionnats en ce qui concerne leur langue, leur culture, leur famille, leur nation autochtone, et l'incidence que cela a pu avoir sur les collectivités autochtones à cause de ce cycle de sévices qui a duré très longtemps; cela concerne également le fait qu'ils n'avaient pas de bonnes compétences parentales à cause de leur expérience des pensionnats, du traumatisme historique qu'ils ont connu — et nous avons beaucoup appris à ce sujet dernièrement — et de la douleur et du chagrin qu'ont ressentis les peuples autochtones au cours de nombreuses années de déplacement, de perte de culture et de langue, et de mortalité dans leurs propres collectivités*[210].

Selon elle, « il faut en moyenne une dizaine d'années à une communauté pour mettre fin à la dénégation, créer un sentiment de sécurité et amener les gens à prendre part au processus de guérison »[211]. Sur le million d'Autochtones vivant actuellement au Canada, plus d'un tiers a été touché par l'expérience des pensionnats, soit directement pour avoir fréquenté un pensionnat, soit indirectement pour avoir fait partie de la famille ou de la collectivité associée aux survivants.

14.4 STRATÉGIE DE BIEN-ÊTRE ET DE GUÉRISON

Comment donc bâtir et rétablir le bien-être de tous les peuples autochtones? Un message clair ressort des multiples mémoires et interventions de particuliers: il faut de toute urgence adopter, à l'intention des Premières nations, des Inuits et des Métis, une stratégie de bien-être et de guérison, dotée d'un plan d'action clair qui peut être et sera appliqué. Il faut agir sur le plan de la santé mentale en général de manière à obtenir des résultats concrets pour la collectivité.

Il faut de toute urgence adopter une stratégie de bien-être et de guérison, dotée d'un plan d'action clair qui peut être et sera appliqué.

Toutes les approches doivent être axées sur les grands déterminants de la santé et appeler tous les secteurs économiques, sociaux, culturels et médicaux à participer et à collaborer.

La stratégie doit intégrer tous les groupes — Indiens (inscrits et non inscrits), Métis et Inuits — de toutes les régions du pays.

En 2001, au Canada, dans le groupe des Autochtones se définissant comme tels, les Indiens d'Amérique du Nord étaient les plus nombreux, soit 62 p. cent; 505 000 environ de ces derniers avaient le statut d'Indien inscrit et 104 000 n'avaient pas ce statut. Les Métis, soit

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[210] 21 juin 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/23evb-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

[211] 20 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/27eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

292 000 personnes, représentaient quelque 30 p. cent du groupe et les Inuits, soit 45 000 personnes, en représentaient 5 p. cent[212].

Il est difficile de faire des généralisations sur l'état de santé mentale en général et des besoins en la matière des peuples autochtones, étant donné la multiplicité de personnes qui se reconnaissent comme tels. D'ailleurs, les témoins ont souligné la valeur des approches conçues pour répondre aux besoins particuliers de chaque groupe.

> *En outre, nous savons qu'une démarche unique destinée à ces trois groupes reconnus par la Constitution n'est pas non plus la bonne solution. Toute démarche doit être propre à chaque nation.* — *Bernice Downey*[213]

Pour presque tous les témoins, le bourbier juridictionnel actuel est la principale entrave à un véritable cheminement vers le bien-être et une bonne santé mentale.

Et quelles sont certaines des principales composantes d'une telle compilation de stratégies? Pour les témoins, toutes les approches doivent être axées sur les grands déterminants de la santé et appeler tous les secteurs économiques, sociaux, culturels et médicaux à participer et à collaborer.

> *Une stratégie exhaustive doit englober des changements au système d'éducation et des moyens de créer des possibilités de développement économique; il ne s'agit pas seulement que d'étudier la santé mentale, la violence familiale et le suicide. Tous ces éléments sont interreliés* — *Debbie Dedam-Montour*[214]

> *Le développement économique, le logement adéquat, l'éducation, l'équité entre les sexes, la protection de l'environnement et les questions juridiques ne sont que quelques enjeux qui nécessitent une approche vigoureuse et holistique* — *Jennifer Dickson*[215]

Pour presque tous les témoins, le bourbier juridictionnel actuel est la principale entrave à un véritable cheminement vers le bien-être et une bonne santé mentale. Tous les peuples autochtones (Premières nations, Métis ou Inuits) sont désavantagés, mais chacun a été

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212 Ces données s'appuient sur les données fournies par Statistique Canada dans le cadre de la Séance de suivi sectoriel sur la santé de la Table ronde Canada — Autochtones de novembre 2004. Il s'agit de quatre documents : *Profil de la population des Indiens de l'Amérique du Nord au Canada ayant le statut d'Indien inscrit*; *Profil de la population des Indiens de l'Amérique du Nord au Canada sans statut d'Indien inscrit*; *La population métisse du Canada* et *La population inuite du Canada*, http://www.aboriginalroundtable.ca/sect/hlth/index_f.html.

213 21 avril 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/13evb-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

214 20 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/27evb-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

215 20 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/27eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

contraint, pour des raisons législatives et administratives, à entretenir des liens différents avec le gouvernement fédéral et donc se retrouve dans une situation différente pour ce qui est de la prestation de programmes et de services par le gouvernement provincial et territorial. Choquée de cette situation, Donna Lyon, directrice, Organisation nationale de la santé autochtone, a appelé le gouvernement fédéral à admettre :

> *... qu'il a l'obligation en vertu d'un traité ou de la Constitution, selon le cas, d'offrir des programmes de santé aux trois peuples autochtones*[216]...

Les témoins ont convenu des composantes essentielles d'une bonne stratégie. Pour eux, il est essentiel de se concentrer sur les déterminants de la santé et de clarifier les compétences et les responsabilités des divers ministères en matière de santé globale des peuples autochtones. Ils ont insisté sur le fait que, une fois mise en place, une telle stratégie permettrait d'éviter bon nombre des problèmes de santé mentale que connaissent les individus et les collectivités.

Le Comité appuie fermement l'élaboration d'une stratégie visant la promotion du bien-être, le rétablissement de la santé mentale et la prévention d'une aggravation de la santé mentale des peuples autochtones.

Le Comité appuie fermement l'élaboration d'une stratégie visant la promotion du bien-être, le rétablissement de la santé mentale et la prévention d'une aggravation de la santé mentale des peuples autochtones. Cette stratégie doit être capable d'améliorer de façon mesurable l'état de santé global de l'ensemble des peuples autochtones et de tenir compte des besoins distincts des Premières nations, des Inuits et des Métis où qu'ils vivent. La stratégie doit miser sur des partenariats reconnus et une collaboration authentique entre secteurs sociaux, économiques, médicaux et autres; le but visé est en gros de trouver des solutions adaptables et multidimensionnelles aux problèmes complexes que connaissent les peuples autochtones par la voie d'une véritable participation communautaire et du partage du pouvoir concernant l'application des changements.

La stratégie doit miser sur des partenariats reconnus et une collaboration authentique.

En 2003, les premiers ministres canadiens ont demandé à leur ministre de la santé de consulter les peuples autochtones à propos d'un cadre visant la préparation de rapports sur l'état de santé des Autochtones[217]. Les rapports doivent renseigner la population sur les progrès réalisés et les principaux résultats en s'appuyant sur des indicateurs permettant d'établir des comparaisons entre Canadiens autochtones et non autochtones. Les rapports doivent également informer la population canadienne des programmes en vigueur et des dépenses courantes et fournir des données de référence à partir desquelles il sera possible d'évaluer les nouveaux investissements, niveaux de service et résultats. Ces données sont essentielles à la réussite de toute stratégie relative au bien-être et à la guérison.

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[216] 20 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/27eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

[217] Santé Canada (septembre 2004), Information : Accord de 2003 des premiers ministres sur le renouvellement des soins de santé, http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2003accord/index_f.html.

La stratégie doit préciser l'autorité responsable de son exécution, le mode de mesure du bien-être, les objectifs à atteindre, le moment où les mesures concrètes seront mises en place et les critères permettant de juger des résultats. Il est essentiel de prévoir un calendrier précis pour la mise en place d'initiatives et l'évaluation des résultats ainsi qu'un mécanisme de financement durable et suffisant.

Le Comité recommande :

93	**Qu'en priorité la Commission canadienne de la santé mentale (voir le Chapitre 16), avec la participation pleine et entière de son Comité consultatif des Autochtones, élabore une stratégie en matière de bien-être et de guérison sur le plan de la santé mentale pour l'ensemble des peuples autochtones.** **Que la stratégie énonce des buts, ainsi qu'un calendrier d'application, et des recommandations sur la façon d'évaluer les résultats.** **Que la stratégie prévoie des approches distinctes pour les Premières nations, les Inuits et les Métis.**

14.5 AGIR SUR LES DÉTERMINANTS DE LA SANTÉ POUR CHAQUE GROUPE

Des facteurs clés plus généraux — revenu et statut social, réseaux d'entraide sociale, niveau d'instruction, emploi, environnement social et physique, pratiques personnelles en matière de santé et capacité d'adaptation, enfance, patrimoine biologique et génétique, services de santé, sexe et culture — influent sur la santé mentale.

Des témoins ont fait valoir que, pour être valable, toute stratégie doit s'appuyer sur la prise en compte de l'ensemble des conditions ou déterminants de la santé qui contribuent au piètre état de santé des peuples autochtones. Ils ont montré comment des facteurs clés plus généraux — revenu et statut social, réseaux d'entraide sociale, niveau d'instruction, emploi, environnement social et physique, pratiques personnelles en matière de santé et capacité d'adaptation, enfance, patrimoine biologique et génétique, services de santé, sexe et culture — influent sur la santé mentale. Mais, surtout, ils ont expliqué comment l'on pouvait éviter bon nombre de problèmes de santé physique et mentale chez les peuples autochtones en améliorant chacun des ces déterminants.

14.5.1 Approches propres à chaque groupe et culture

Au dire de certains témoins, la guérison, la langue et la culture traditionnelles sont d'une importance critique pour ce qui est de surmonter les attitudes et les comportements négatifs.

Comme nous l'avons déjà dit, les peuples autochtones sont très divers. Même parmi ceux qui se sont identifiés comme Indiens d'Amérique du Nord (près de 65 p. cent), Métis (30 p. cent) ou Inuits (5 p. cent), il existe bien des pratiques culturelles, des liens, des langues

et des situations sociales, économiques et géographiques dans les limites territoriales du Canada.

Pour les Premières nations, plus de la moitié (52 p. cent) des Indiens d'Amérique du Nord ayant le statut d'Indien inscrit vivaient dans des réserves, selon le recensement de 2001. Des témoins ont affirmé que l'existence même des réserves nuisait à la santé mentale des Indiens d'Amérique du Nord, phénomène souvent exacerbé par l'éloignement.

Comme l'a fait remarquer James Morris, directeur exécutif, Nodin Counselling Services, du nord de l'Ontario :

> *Je n'ai pas besoin de parler de l'environnement dans lequel vivent ces gens; ils vivent dans une pauvreté débilitante, dans des collectivités isolées. C'est la même histoire dans n'importe quelle région isolée, où les gens sont pauvres. Le contexte est le même dans toutes les collectivités des Premières nations. Je ne pense jamais à une réserve comme à un environnement normal pour les peuples des Premières nations*[218].

Pour les Inuits, la situation géographique crée certains besoins sur le plan de la prestation de programmes et de services. Cinq des plus importantes collectivités inuites (qui comptent entre 1 500 et 3 000 personnes) sont regroupées au-dessus ou à proximité du 60e parallèle dans les territoires de l'Ouest et les provinces de l'Est. On a rappelé au Comité que ce n'est qu'au cours des 50 dernières années, le gouvernement fédéral établissant une présence significative dans l'Arctique, que les Inuits ont été déplacés de leurs campements saisonniers et réinstallés de façon permanente.

Selon Jennifer Dickson :

> *Au cours des années 1950, [des Inuits installés dans des campements saisonniers et de plus petites collectivités] ont été contraints de déménager dans d'autres localités, les autorités religieuses, médicales et gouvernementales ayant statué que la vie dans de plus grands centres améliorerait leur bien-être social et économique. Au contraire, ce déménagement allait profondément bouleverser la dynamique historique et culturelle de la côte nord, et avoir un impact durable sur les familles affectées*[219].

Pour les Métis, l'histoire a également été déterminante — surtout le fait que leur relation avec les autres Canadiens ne soit pas encore régie par des traités ou des règlements de revendications territoriales. En 2001, plus d'un quart de tous les Métis vivait en Alberta, et cette province est la seule qui ait délégué par voie législative aux établissements métis le pouvoir d'élaborer, dans certaines limites, des décrets et des politiques dans quelques régions

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[218] 20 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/27evb-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

[219] 20 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/27eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

précises du Nord. Près de 70 p. cent de l'ensemble des Métis du Canada vivent cependant dans des villes (en dehors d'établissements particuliers), où résident également plus de sept sur 10 (73 p. cent) des Indiens d'Amérique du Nord sans statut d'Indien inscrit.

Au dire de certains témoins, la guérison, la langue et la culture traditionnelles sont d'une importance critique pour ce qui est de surmonter les attitudes et les comportements négatifs. Tarry Hewitt a appelé à des décisions communautaires à propos des pratiques de guérison traditionnelles ou conventionnelles mais a souligné que :

> *La promotion des pratiques de guérison traditionnelle passe par la reconnaissance de leur efficacité et la mise en valeur des ressources humaines afin de surmonter les habitudes de dépendance et de restaurer l'estime de soi des Autochtones et la confiance dans leur culture*[220]...

Dans le même esprit, Jennifer Dickson a appuyé les approches culturellement pertinentes :

> *La culture et le savoir traditionnels sont au cœur de la santé et du bien-être des Inuits. La sagesse des Inuits et leurs façons de faire doivent être intégrées dans tous les programmes pour qu'ils aient des répercussions positives sur la santé des personnes et de la communauté*[221].

14.5.2 Des appuis familiaux et communautaires

Bon nombre de témoins ont tenu à souligner que des familles et des collectivités solides sont essentielles à la réalisation du bien-être général. Ils ont reconnu que les choix personnels sont importants, mais ont noté la forte influence de facteurs sociaux collectifs sur bon nombre de décisions que les peuples autochtones prennent à propos de leur vie.

Bernice Downey a décrit comment les familles saines forment des collectivités fortes :

> *Lorsqu'on parle de santé mentale, on se tourne du côté des familles en bonne santé. Ces familles trouvent le moyen de subvenir à leurs besoins, elles ont un but dans la vie, elles ont un emploi qui leur permet de contribuer à la société. Elles peuvent vivre leur vie sans être empêchées de le faire à cause des restrictions sur la chasse, par exemple, et elles peuvent enseigner leurs traditions à leurs enfants et leurs enfants peuvent alors poursuivre sur la même lancée. C'est ça, la santé mentale pour une communauté*[222].

D'autres témoins ont souligné que des relations sociales chaleureuses et des réseaux d'entraide assurent une stabilité aux gens et les aident à résoudre leurs problèmes et à

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220 16 juin 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/22evc-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

221 20 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/27eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

222 21 avril 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/13evb-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

affronter l'adversité. Tous ceux qui se sentent incapables de contrôler les circonstances de leur vie se sentent moins bien globalement. Bill Mussell a proposé le concept de « prise en charge » comme moyen de protéger les gens contre certains problèmes :

> *J'aime la notion de prise en charge. Nos jeunes se sentent comme des sans-abri même s'ils ont un toit. Ils ont une maison, mais pas de foyer. Les personnes qui doivent s'occuper d'eux ne sont pas là ni les personnes qu'ils aiment et ceux qu'ils souhaiteraient voir prendre soin d'eux*
>
> *La question qu'il faut plutôt poser est celle-ci : Que doit-on faire, avec des ressources limitées, pour favoriser cette prise en charge?*
>
> *Je ne crois pas qu'on puisse l'acheter, mais on peut certes faire en sorte qu'elle se développe*[223].

La fréquence avec laquelle les peuples autochtones changent de lieu de résidence est préoccupante. Il s'ensuit un manque de continuité dans les liens sociaux ainsi qu'une perte du sentiment communautaire. Selon des données du recensement, il semblerait que la population des réserves est relativement stable, bien qu'un tiers (33 p. cent) de la population indienne d'Amérique du Nord ayant le statut d'Indien inscrit et vivant dans des grandes villes ait déménagé chaque année. De même, 25 p. cent de la population indienne d'Amérique du Nord sans statut d'Indien inscrit et 23 p. cent de la population métisse déménagent chaque année — soit deux fois plus souvent que les peuples non autochtones (14 p. cent).

14.5.3 Les enfants et les jeunes

Dans tous les groupes autochtones, la population est beaucoup plus jeune que dans le reste de la population.

Dans tous les groupes autochtones, la population est beaucoup plus jeune que dans le reste de la population. Ce sont les Inuits qui ont la population la plus jeune, puisque l'âge médian n'est que de 20,6 ans, contre 37,7 ans pour la population non autochtone. Ceci signifie que, parmi les Inuits, 40 p. cent sont des enfants de moins de 15 ans. Ce pourcentage est de 30 p. cent chez les Métis et, dans la population indienne d'Amérique du Nord, de 25 p. cent chez ceux ayant le statut d'Indien inscrit et de 35 p. cent chez ceux sans statut d'Indien inscrit.

Les enfants sont particulièrement visés par divers types d'aide sociale, l'environnement physique, la stabilité familiale et le statut socio-économique. James Morris a évoqué son expérience et ses observations sur l'importance critique d'un appui adéquat pour les jeunes.

> *Je connais des enfants qui ont faim, qui sont mal vêtus ou qui n'ont pas d'endroit où dormir. Dans une communauté, j'ai vu un groupe de 18 personnes vivant ensemble dans une petite roulotte contenant seulement trois lits. Chacun dormait à tour de rôle. Lorsqu'une nuit ce n'était pas*

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[223] 20 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/27evb-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

au tour de l'enfant de dormir, il n'allait pas à l'école le lendemain. Il devait aller au lit quand tous les autres se levaient. La pauvreté est un problème important dans les réserves et elle a une incidence sur les enfants, à mon avis[224].

Gloria Laird, co-présidente, Alberta Mental Health Board, Wisdom Committee, a exposé les difficultés liées au fait qu'un grand nombre d'enfants et de jeunes autochtones sont visés par un réseau de services sociaux dont un très faible pourcentage des membres du personnel est autochtone. Elle a également laissé entendre qu'une forte proportion des prostitués enfants en Alberta est autochtone et a des besoins particuliers que le système actuel ne comble pas.

Ça fait des années que je demande qu'on crée un centre de guérison holistique. Mais cela n'a rien donné. On peut discuter jusqu'à plus soif, mais rien ne change. Ce sont les jeunes qui disent qu'ils veulent aller en campagne en compagnie des aînés. Ce sont eux qui demandent de faire des sueries afin de se purifier. Il leur faut des solutions innovatrices. Ils doivent quitter les villes.

Qui créera un centre de guérison holistique pour ces jeunes qui n'ont pas de voix? Les enfants sont de plus en plus jeunes; ils ont maintenant 10 et 11 ans. Il est difficile d'arrêter de se prostituer quand on est toxicomane et qu'on consomme les drogues comme le crystal meth[225].

L'établissement de stages pour les jeunes; la création d'emplois pour les jeunes, la promotion des valeurs et des enseignements traditionnels, les consultations des services de police de Winnipeg et de la GRC, la sensibilisation à la sécurité sur les lieux de travail et la promotion de la prévention du suicide.

Les témoins ont plaidé en faveur de la mise en place de mécanismes d'aide destinés aux jeunes adultes à mesure que ces derniers comprennent le monde et leur place en son sein. Jason Whitford, coordonateur du Conseil pour la jeunesse, Assemblée des Chefs du Manitoba, a décrit le travail effectué dans un certain nombre de secteurs importants : l'établissement de stages pour les jeunes; la création d'emplois pour les jeunes, la promotion des valeurs et des enseignements traditionnels, les consultations des services de police de Winnipeg et de la GRC, la sensibilisation à la sécurité sur les lieux de travail et la promotion de la prévention du suicide. Le but visé est d'encourager les jeunes à participer au changement et de promouvoir le leadership de ces derniers à cet égard :

Nous disons aux jeunes que s'ils n'aiment pas la tournure des choses et s'ils sont suffisamment nombreux, ils peuvent prendre le contrôle de leurs collectivités et les remodeler à leur manière. Les organismes bénévoles, les conseils de jeunes, les organisations de jeunes leur donnent les moyens de

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224 20 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/27evb-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

225 9 juin 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/21evb-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

s'attaquer au problème et d'offrir des possibilités aux autres jeunes de leur entourage. Ils veulent changer la situation dans leurs collectivités, mais il y a beaucoup de jeunes qui n'ont pas les moyens de s'exprimer eux-mêmes de façon positive[226].

14.5.4 Les conditions socio-économiques

Des témoins ont dégagé diverses conditions socio-économiques qui ont influé sur leur santé et leur bien-être global. En général, les inégalités sur le plan du revenu pour les peuples autochtones se sont corrigées à la faveur d'un meilleur accès à l'éducation et à l'emploi, ce qui s'est répercuté sur l'accès au logement, l'alimentation et d'autres nécessités de la vie, matérielles et sociales.

Pour trop d'Autochtones, le chômage ou le sous-emploi est la principale cause de leur piètre état de santé.

Parmi les groupes autochtones, ce sont les Métis qui ont déclaré le revenu moyen le plus élevé en 2000, soit 22 000 $ environ, ce qui est inférieur de près de 8 000 $ au revenu moyen des non autochtones. Divers facteurs nuisent à la faculté des peuples autochtones d'avoir un revenu. Il faut mentionner le manque d'instruction, puisque celui-ci est directement lié aux possibilités d'emploi et que le nombre de personnes n'ayant pas terminé leurs études secondaires est presque deux fois plus élevé chez les Autochtones que chez les autres Canadiens. Notons aussi la jeunesse de la population autochtone, 40 p. cent seulement des Inuits étant en âge de travailler (et donc ayant entre 25 et 65 ans).

Les facteurs comme le logement et l'infrastructure communautaire se répercutent sur le bien-être psychologique. Il est particulièrement significatif que les ménages autochtones (Indiens, Inuits et Métis) sont beaucoup plus susceptibles que leurs homologues non autochtones de vivre dans des logements ne satisfaisant pas à des normes de qualité acceptables.

L'emploi ne fournit pas seulement un revenu permettant de se procurer les nécessités de la vie, comme le logement et l'alimentation, mais il assure également un sentiment d'identité et un but précis, des contacts sociaux et des possibilités de croissance personnelle. Pour trop d'Autochtones, le chômage ou le sous-emploi est la principale cause de leur piètre état de santé. Comme en a témoigné Elsie Bastien, non seulement l'emploi est limité mais, en raison de règles relatives à l'aide sociale, les Autochtones ne peuvent participer librement à d'autres activités valorisantes :

> *La plupart de nos gens sont en chômage parce qu'ils ne trouvent pas d'emplois, notre taux de chômage atteignant les 85 p. 100. La communauté a cherché à subventionner les gens pour qu'ils puissent suivre une formation, ce qui leur aurait permis de travailler ensuite dans certains de ces programmes comme bénévoles. Mais au début de l'année, le gouvernement fédéral a modifié la loi pour tenir compte, à mon avis, de ce que fait la province. Par conséquent, une bonne partie de ces gens qui*

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[226] 31 mai 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/16evb-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

auraient pu faire du travail communautaire pour nous, ne peuvent plus le faire puisque nous n'avons pas les fonds voulus pour les rémunérer et puisqu'ils doivent désormais se chercher du travail rémunéré. Ils doivent démontrer qu'ils ont continué à chercher un emploi rémunéré, avant de pouvoir toucher leur chèque de bien-être à la fin du mois[227].

Les facteurs comme le logement et l'infrastructure communautaire se répercutent sur le bien-être psychologique. Il est particulièrement significatif que les ménages autochtones (Indiens, Inuits et Métis) sont beaucoup plus susceptibles que leurs homologues non autochtones de vivre dans des logements ne satisfaisant pas à des normes de qualité acceptables (logements ayant besoin de réparations majeures) et de confort (trop grand nombre d'occupants par logement).

Larry Gordon a expliqué :

> *Dans bien des régions, la pénurie de logements fait rage. Il ne faut pas sous-estimer les retombées sur la santé mentale de situations où les familles s'entassent à un point où certaines personnes doivent dormir par terre ou attendre leur tour pour dormir. Les sans-abri, quant à eux, font la tournée de leur parenté pour tâcher de trouver un endroit où passer la nuit*[228].

14.5.5 Les femmes

Pour consolider la santé mentale des hommes et des femmes des collectivités autochtones, il faut changer les pratiques et les priorités. Plusieurs témoins ont souligné la nécessité de prendre davantage conscience des différences et de l'équilibre selon les sexes au sein des familles et des collectivités ainsi qu'au sein des structures et des initiatives organisationnelles et gouvernementales.

Actuellement, les rôles, les comportements et les relations de pouvoir désavantagent doublement les femmes — parce qu'elles sont femmes et parce qu'elles sont Autochtones.

Les femmes jouent un rôle primordial dans la venue de changements réels et l'obtention de résultats pour les collectivités autochtones. La force des femmes est le principal déterminant de leur propre santé mentale, et de celle de leur famille et de leur collectivité.

Actuellement, les rôles, les comportements et les relations de pouvoir désavantagent doublement les femmes — parce qu'elles sont femmes et parce qu'elles sont Autochtones. Des témoins ont signalé que les services offerts aux femmes autochtones et les soutiens connexes à leurs enfants sont moins nombreux, moins efficaces et de moindre qualité que ceux fournis aux Canadiens dans leur ensemble.

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[227] 9 juin 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/21evb-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

[228] 21 avril 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/13evb-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

Or les femmes jouent, semble-t-il, un rôle primordial dans la venue de changements réels et l'obtention de résultats pour les collectivités autochtones. Bill Mussell a souligné que la force des femmes est le principal déterminant de leur propre santé mentale, et de celle de leur famille et de leur collectivité. Jennifer Dickson a ajouté :

> *Les femmes inuites sont véritablement les agents du changement dans l'Arctique canadien. Si elles sont motivées, incluses et appuyées, elles peuvent contribuer, et contribueront, considérablement à l'établissement de collectivités solides, stables, saines et heureuses*[229].

14.5.6 Recommandations

Le Comité a écouté attentivement les témoignages sur les principaux déterminants de la santé et a convenu que ceux-ci étaient primordiaux pour la santé mentale, que ce soit celle des individus, des familles, des collectivités ou des peuples autochtones en général. Il reconnaît qu'il faut un plan d'action axé sur les multiples déterminants de la santé et sur les interactions complexes entre ces derniers. Compte tenu de la multitude de facteurs qui causent des problèmes mentaux chez les peuples autochtones, toute stratégie visant à y remédier doit être fondée sur des preuves claires, portant à la fois sur les problèmes particuliers et sur l'ampleur des mesures nécessaires.

Le Comité recommande :

94	**Que la Commission canadienne de la santé mentale (voir le Chapitre 16), en consultation avec son Comité consultatif autochtone, élabore, en tant que composante intégrale de la stratégie en matière de bien-être et de guérison dans le domaine de la santé mentale, un plan qui :** • **dégagerait les principaux déterminants de la santé;** • **évaluerait l'effet de ces déterminants sur la santé mentale;** • **préciserait les mesures à mettre en place et** • **établirait les calendriers et les niveaux de financement nécessaires pour encourager bien-être et guérison.**

[229] 20 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/27eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

14.6 AGIR SUR LES CHAMPS DE COMPÉTENCE

Le Comité s'est fait dire à maintes reprises que le flou entourant les champs de compétence relatifs aux peuples autochtones est l'un des principaux obstacles à l'édification d'un système cohérent et intégré de planification et de fourniture des services en matière de bien-être et de santé mentale.

Le flou entourant les champs de compétence relatifs aux peuples autochtones est l'un des principaux obstacles à l'édification d'un système cohérent et intégré de planification et de fourniture des services en matière de bien-être et de santé mentale.

Les membres des Premières nations qui sont des Indiens inscrits vivant dans des réserves bénéficient d'un certain nombre de programmes et services en matière de santé mentale; mais ce n'est plus le cas lorsqu'ils quittent la réserve. Lorraine Boucher, directrice des programmes de santé, North Peace Tribal Council, a expliqué :

> *Je constate que la classe politique se renvoie constamment la balle quand il est question de l'accès des membres des Premières nations aux services. Quand nous habitons dans la réserve, nous relevons du gouvernement fédéral. Quand nous habitons à l'extérieur de la réserve, nous relevons du gouvernement provincial*[230].

Pour les Inuits, la situation est analogue. Onalee Randell a fait valoir que ce sont ceux qui ont besoin des services qui pâtissent du différend qui existe encore relativement aux champs de compétence :

> *Le débat entourant les responsabilités continue, que ce soit celles du gouvernement fédéral ou celles des gouvernements provinciaux et territoriaux. En fait, ce débat a fini par devenir plus important que la prestation de services aux Inuits et fait obstacle à cette prestation dont on a grand besoin*[231].

À l'instar des Indiens d'Amérique du Nord sans statut d'Indien inscrit, les Métis connaissent des problèmes de santé mentale qui sont comparables à ceux des Premières nations et des Inuits, mais ils doivent constamment se battre sur le front de la reconnaissance des responsabilités au sein de la fédération canadienne. Le gouvernement fédéral ne se reconnaît pas de responsabilités particulières pour les Métis ou les Indiens non inscrits, tandis que les provinces et les territoires hésitent à demandent des éclaircissements juridiques. De nombreux Métis désirent simplement savoir précisément s'ils tombent sous la responsabilité du gouvernement fédéral ou provincial, de manière à pouvoir avoir accès plus facilement aux services dont ils ont besoin.

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230 20 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/27evb-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

231 20 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/27eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

Les Métis ont besoin de services de santé mentale adaptés à leur culture. Le nombre de travailleurs métis en santé mentale doit augmenter comme c'est le cas chez les Inuits et les Premières nations en général. Il faut aussi accroître les services à leur égard et régler le problème des compétences de sorte qu'ils aient accès aux programmes fédéraux ou provinciaux de santé mentale destinés aux Autochtones — Donna Lyon[232].

14.6.1 Définir le rôle du gouvernement fédéral

Actuellement, tous les ordres de gouvernement cultivent une certaine ambivalence à propos de leurs responsabilités en matière de santé des peuples autochtones. La *Loi constitutionnelle de 1867*, qui prévoyait (aux articles 91 et 92) une séparation des pouvoirs entre le parlement fédéral et les assemblées législatives provinciales, stipulait que la responsabilité des peuples autochtones variait selon les catégories, certaines obtenant le statut par reconnaissance du fédéral, d'autres non.

Pour le gouvernement fédéral, la *Loi sur les Indiens* est le point de référence en matière de services aux Indiens inscrits vivant dans des réserves et à certains Inuits. Dans le sillage de son engagement de 2004 visant à mettre sur pied un Secrétariat des Inuits au sein d'Affaires indiennes et du Nord Canada, le gouvernement fédéral a commencé à jouer un rôle public plus précis pour ce qui est de son approche des questions propres aux Inuits. Depuis 1985, sauf pour les programmes qui visent la population canadienne en général, les Métis et les Indiens non inscrits s'adressent à leur interlocuteur fédéral, nommé par le gouvernement, plutôt qu'à un ministère fédéral en particulier.

Les gouvernements provinciaux et territoriaux hésitent à fournir un financement ou des services aux Autochtones, car ils craignent d'être perçus comme acceptant cette responsabilité. Cette ambivalence généralisée est particulièrement grave en matière de santé mentale, car les programmes et les services pertinents englobent forcément l'éducation, le logement, l'emploi et l'aide sociale, de même que la santé — autant de domaines qui sont en général perçus comme de compétence provinciale ou territoriale.

Il n'y avait aucune ambivalence chez les témoins qui ont comparu devant le Comité et qui ont appelé à un éclaircissement des relations avec le gouvernement fédéral. L'organisation de la Table ronde Canada — Autochtones, en 2004, a été perçue, pour les Premières nations, les Inuits et les Métis, comme un premier pas vers l'autodétermination fondée sur les droits des Autochtones[233]. À la fin mai 2005, des organismes représentant divers groupes ont signé

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[232] 20 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/27eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

[233] Canada-Autochtones- Table ronde, Rapport récapitulatif final (par les animateurs), http://www.aboriginalroundtable.ca/sect/ffr/index_f.html

plusieurs déclarations qui énonçaient des mesures particulières visant à préciser encore les relations avec le gouvernement du Canada[234].

Des témoins ont évoqué une nouvelle relation spéciale avec le gouvernement du Canada qui se démarquerait des interactions actuelles, auxquelles participent plusieurs ministères. Irene Linklater a insisté sur la nécessité de rétablir le lien spécial avec la Couronne. Elle a expliqué que les Premières nations désiraient :

> *...des relations directes, sinon avec le premier ministre, du moins avec le Conseil privé, ainsi qu'avec les principaux organismes de décision qui ont pris des dispositions financières directement avec les Premières nations, bref des relations directes entre les Premières nations et le gouvernement fédéral ou, si vous préférez, des relations de nation à nation*[235]*...*

14.6.2 Focaliser les efforts des ministères fédéraux

Au niveau fédéral, les domaines qui sont déterminants pour la santé mentale des peuples autochtones sont de la compétence de plusieurs ministères fédéraux. Il existe à cet égard une extrême fragmentation, étant donné que plusieurs ministères offrent des programmes ou services particuliers à certains groupes de peuples autochtones. Dans la plupart des cas, les services sont fournis exclusivement aux Premières nations vivant dans des réserves; dans d'autres, ils sont offerts seulement aux Premières nations vivant en dehors des réserves; d'autres encore touchent les Inuits et quelques-uns sont axés sur les Autochtones de façon plus générale.

Jusqu'ici, il n'existe aucune estimation sur les sommes totales dépensées par le fédéral au titre de la santé mentale, des maladies mentales et de la toxicomanie chez les Autochtones.

Les peuples autochtones estiment que l'obligation de traiter avec plusieurs ministères est une entrave d'importance, un véritable handicap.

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En 2005, 16 ministères et organismes fédéraux ont offert aux Autochtones des programmes qui se sont chiffrés en tout à quelque 9,1 milliards de dollars. Affaires indiennes et du Nord Canada a dépensé les deux tiers environ de cette somme (soit 6 milliards de dollars), Santé Canada près de 2 milliards de dollars, tandis que les autres ministères et organismes en ont dépensé légèrement plus d'un milliard de dollars[236]. Jusqu'ici, il n'existe aucune estimation sur les

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234 Affaires indiennes et du Nord Canada (31 mai 2005), Communiqué, « Réunion de réflexion conjointe des ministres fédéraux et des dirigeants autochtones nationaux », http://www.ainc-inac.gc.ca/nr/prs/m-a2005/2-02665_f.html

235 1er juin 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/16evc-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

236 Affaires indiennes et du Nord Canada, Budget des dépenses de 2005-2006 : Rapport sur les plans et priorités, « Partenaires fédéraux », http://www.tbs-sct.gc.ca/est-pre/20052006/INAC-AINC/pdf/INAC-AINCr56_f.pdf

sommes totales dépensées par le fédéral au titre de la santé mentale, des maladies mentales et de la toxicomanie chez les Autochtones.

Sauf pour ce qui est de certaines obligations précisées dans la *Loi sur les Indiens* et administrées par le ministère des Affaires indiennes et du Nord, le gouvernement fédéral a permis l'élaboration d'un fondement différent pour chaque ensemble de programmes et de services fournis aux peuples autochtones. Ni la *Loi constitutionnelle de 1867*, ni celle de 1982 ne prévoit de compétence législative ni n'impose d'obligation juridique aux ministères ou organismes fédéraux pertinents.

Les peuples autochtones estiment que l'obligation de traiter avec plusieurs ministères est une entrave d'importance, un véritable handicap. Pour les Premières nations, la répartition des programmes sociaux et du financement connexe entre deux ministères a créé un fossé sur le plan de la santé et des relations des Premières nations avec la Couronne et le gouvernement du Canada :

> *...permettez-moi de [...] souligner [...] une lacune — sur le plan des relations du fait que, d'une part, les dispositions constitutionnelles établies par le Canada ont permis de créer un organisme administratif appelé les Affaires indiennes, et que, d'autre part, ses pouvoirs à ce chapitre sont maintenant délégués à un ministère fédéral, soit Santé Canada, ou plus précisément la DGSPNI, structure qui filtre l'argent. Cela s'est fait, notez bien, sans notre concours. — Irene Linklater*[237].

À propos des Inuits, Onalee Randell a signalé que, parce que tant de ministères entrent en jeu, les compétences sont morcelées entre divers ministères, perpétuant les différends à ce propos :

> *Le débat entraîne aussi de mauvaises communications et une mauvaise coordination entre non seulement les fournisseurs de services de santé de différentes régions, mais aussi entre les agences intergouvernementales. Les responsables du logement ne veulent jamais parler de l'effet du logement sur la santé mentale. Les responsables de l'éducation ne veulent jamais parler de révision ou de changement des programmes d'études afin d'inculquer à l'étudiant l'estime de soi et des habiletés d'adaptation*[238].

Pour les Métis, le problème vient de ce qu'il n'y a tout simplement pas de centralisation au niveau des ministères ou du gouvernement. Ni Affaires Indiennes et du Nord Canada ni Santé Canada n'assument la responsabilité expresse de la question. Toutefois, selon Gloria Laird, co-présidente, Alberta Mental Health Board, Wisdom Committee, on

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[237] 1er juin 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/16evc-f.htm?Language=F&Parl=38&Ses=1&comm_id=47

[238] 20 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/27eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

commence à chercher des moyens de centraliser au niveau d'un ministère les interventions répondant aux besoins en services de santé du peuple métis[239].

14.6.3 Recommandations

Le Comité reconnaît que, pour qu'un plan d'action et une stratégie réussissent, il faut régler cette ambivalence sur le plan des champs de compétence ou du moins les remplacer par des énoncés clairs de responsabilités. Actuellement, les peuples autochtones sont très mobiles et les chevauchements de compétence abondent. Le fait de vivre dans une réserve puis d'en sortir ainsi que les déplacements entre provinces et territoires ne devraient pas interrompre la prestation de services, ce qui peut aboutir à la disparition des programmes essentiels à la santé mentale.

Pour qu'un plan d'action et une stratégie réussissent, il faut régler cette ambivalence sur le plan des champs de compétence ou du moins les remplacer par des énoncés clairs de responsabilités.

Des témoins ont dit au Comité que tous les ordres de gouvernement ont toujours rejeté la responsabilité de la détérioration de l'état de santé général des peuples autochtones. Un tel déni a mené au rejet des responsabilités sur d'autres, obscurci les faits et empêché la création de modes d'évaluation des progrès vers une meilleure santé, notamment mentale.

Certains témoins ont clairement dit vouloir une relation plus directe avec la Couronne, par l'entremise du gouvernement du Canada, de manière à être directement responsables de leur propre santé. Mais ils souhaitent que cette responsabilité s'inscrive dans une relation avec le gouvernement du Canada qui reconnaisse la capacité des peuples autochtones de contrôler leur vie s'ils disposent de ressources et d'appuis suffisants.

Le fait de vivre dans une réserve puis d'en sortir ainsi que les déplacements entre provinces et territoires ne devraient pas interrompre la prestation de services, ce qui peut aboutir à la disparition des programmes essentiels à la santé mentale.

Le Parlement du Canada et le gouvernement fédéral ont depuis longtemps la responsabilité du bien-être de l'ensemble des citoyens du Canada, ce qui comprend les peuples autochtones. Un niveau sans précédent de collaboration intergouvernementale et de leadership fédéral est nécessaire pour enrayer l'épidémie de problèmes mentaux, de suicides et de toxicomanie notamment, que connaissent les peuples autochtones. En plus du travail à entreprendre par la Commission canadienne de la santé mentale, il faudra impérativement que le gouvernement fédéral prenne immédiatement des mesures visant à répondre aux besoins des peuples autochtones en matière de santé mentale.

Un niveau sans précédent de collaboration intergouvernementale et de leadership fédéral est nécessaire pour enrayer l'épidémie de problèmes mentaux, de suicides et de toxicomanie notamment, que connaissent les peuples autochtones.

Le Comité estime toutefois que le besoin le plus pressant est de coordonner les efforts du gouvernement fédéral en vue d'améliorer la santé et le bien-être des peuples autochtones au Canada.

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[239] 9 juin 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/21evb-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

Le Comité a analysé plusieurs mesures fédérales qui compléteraient et appuieraient le travail de la Commission canadienne de la santé mentale proposée. Malgré les mécanismes de surveillance parlementaire assurés par les comités permanents des deux chambres et les rapports que présente à l'occasion la vérificatrice générale, les questions touchant les peuples autochtones n'ont pas été examinées avec suffisamment de rigueur ou de continuité par le Parlement. On pourrait établir un mandataire du Parlement, analogue au vérificateur général ou au commissaire aux langues officielles, qui relèverait directement du Parlement (plutôt que d'un ministère ou d'un ministre en particulier).

Une deuxième possibilité, qui s'appuierait sur les initiatives du premier ministre dans le cadre de la Table ronde Canada-Autochtones, serait d'établir une structure permanente similaire à la Table ronde nationale sur l'environnement et l'économie. Constituée comme organe consultatif autonome, cette table ronde favorise les coalitions et tente de réconcilier les positions souvent contradictoires des pouvoirs publics, des secteurs économiques et de la collectivité.

Le Comité estime toutefois que le besoin le plus pressant est de coordonner les efforts du gouvernement fédéral en vue d'améliorer la santé et le bien-être des peuples autochtones au Canada. L'établissement d'un comité chargé des questions autochtones au sein du Cabinet et un secrétariat au Bureau du Conseil privé, combiné à l'engagement pris en 2003 de faire rapport sur la situation des peuples autochtones, devrait faciliter une reconnaissance directe plus grande du lien entre le gouvernement fédéral et les peuples autochtones.

Le Comité recommande :

95	**Que le gouvernement du Canada crée un Comité interministériel composé de sous-ministres des ministères assumant une responsabilité à l'égard des peuples autochtones et présidé par le Bureau du Conseil privé.** **Que ce Comité interministériel prépare un rapport qu'il déposera au Parlement tous les deux ans sur l'incidence du travail de ces ministères sur le bien-être des peuples autochtones et, notamment, mais sans s'y limiter, sur leur santé mentale.** **Que le rapport sur le bien-être des Autochtones comporte une liste de tous les programmes et services fédéraux propres à chaque groupe de peuples autochtones et précise les dépenses effectuées et l'incidence de ces dernières sur les résultats obtenus sur le plan de la santé et, notamment, de la santé mentale;** **Que le Comité interministériel appuie des groupes de travail composés de représentants des Premières nations, des Inuits et des Métis et chargés de fournir des renseignements et des conseils et de vérifier le rapport.**

14.7 AGIR SUR LA PRESTATION DES PROGRAMMES ET SERVICES

Les programmes et services conçus pour maintenir un bon état de santé, empêcher les maladies ou rétablir santé et fonctions constituent également un déterminant de la santé pour les peuples autochtones. Comme nous l'avons déjà souligné, des programmes et services fédéraux particuliers concernant la santé mentale des peuples autochtones sont fournis essentiellement aux Premières nations vivant dans des réserves. Souvent, par extension, ils sont fournis à des clients inuits, mais le sont rarement à des Indiens non inscrits et à des Métis.

Sur les 16 ministères et organismes fédéraux qui offrent des programmes aux peuples autochtones, ce sont Affaires indiennes et du Nord Canada et Santé Canada qui sont les principaux responsables. Le premier est chargé de l'administration de la *Loi sur les Indiens* et fournit en majeure partie les services de base comme l'éducation, l'aide sociale, le logement et l'infrastructure communautaire aux Indiens inscrits vivant dans des réserves et à certaines communautés inuites. Pour certains services de santé, c'est Santé Canada qui est responsable de la prestation de soins primaires par l'entremise de postes de soins infirmiers et de centres de santé destinés aux clients des Premières nations et inuits vivant dans des réserves et dans de nombreuses collectivités éloignées et isolées. Le Programme des services de santé non assurés offre un appui relatif aux médicaments, une intervention en situation de crise et du counselling en santé mentale aux clients inuits et des Premières nations admissibles, quel que soit leur lieu de résidence, lorsqu'ils n'ont pas d'autre assurance.

Des témoins ont fait valoir un certain nombre de conditions essentielles à la réussite des programmes et services en santé mentale, dont le pouvoir et la compétence de la communauté, l'accommodement culturel et l'égalité d'accès. Si ces éléments sont intégrés à la prestation des programmes et services, il serait possible de constituer ce que Bill Mussell a appelé des « pratiques exemplaires » :

> *Nous parlons de faiblesses, de problèmes et d'enjeux, mais nous parlons rarement de nos ressources et de nos forces, et des aspects positifs de notre vie. Quelles sont les pratiques valables que nous appliquons? J'hésite à employer l'expression « pratiques exemplaires », parce que je pense qu'il y a tellement de choses que nous ne savons pas. Si nous devions adhérer à la notion de pratiques exemplaires, je pense que cela reviendrait à nous tirer le tapis de sous les pieds avant d'avoir la chance de réellement cerner, explorer et découvrir ce qui fonctionne vraiment*[240].

[240] 20 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/27evb-f.htm?Language=F&Parl=38&Ses=1&comm_id=47

14.7.1 Pouvoir et compétence de la collectivité

Les témoins ont affirmé que les collectivités autochtones doivent prendre le contrôle de leur destinée en supervisant la conception des programmes et services en santé mentale, de la prestation de ces derniers et de leur pertinence culturelle.

Pour la plupart des témoins, le pouvoir et la compétence relativement aux programmes et aux services sont essentiels à la réussite. Ils ont affirmé que les collectivités autochtones doivent prendre le contrôle de leur destinée en supervisant la conception des programmes et services en santé mentale, de la prestation de ces derniers et de leur pertinence culturelle. Valerie Gideon a déclaré que, à moins que les Premières nations ne se sentent maîtres et responsables d'un ensemble complet de programmes de bien-être mental, tout nouvel investissement ou toute nouvelle initiative serait inévitablement voué à l'échec.

Pour d'autres, il est nécessaire de bâtir les capacités de façon à cerner les forces et les compétences au sein de chaque collectivité et famille autochtone. Pour Bill Mussell, « le fondement de l'approche est la constitution d'une capacité communautaire qui soit fiable, sûre et utile dans le contexte du soutien régional et provincial ». Il a précisé :

> *La capacité doit être constituée à tous les niveaux du système : au niveau de la personne, de la communication familiale et de la résolution de problèmes; de l'entraide; des modèles de groupes de soutien qui reflètent la réalité des réseaux communautaires et des relations existantes; de l'offre d'aide au personnel par ses pairs et par d'autres professionnels à l'échelle communautaire, qui offrent des services fondés sur l'éventail d'approches culturelles grand public et complémentaires de la guérison et de l'aide; des ressources régionales, y compris des professionnels très spécialisés, comme des psychologues prêts à mettre leurs compétences à contribution pour entreprendre un processus créatif et collaborateur en vue de concevoir de nouveaux programmes et services; des services provinciaux qui offrent un haut niveau de services spécialisés pour appuyer le renforcement de la capacité nécessaire dans les collectivités*[241].

Il était difficile pour les peuples autochtones de parvenir à une consultation et une participation complètes lorsque les programmes et services étaient identifiés, établis et fournis à l'échelle régionale.

Ian Potter, sous-ministre adjoint, Direction de la santé des Premières nations et des Inuits, Santé Canada, a également reconnu que les collectivités cherchent le pouvoir et le contrôle :

> *Je suis absolument convaincu que des meilleurs résultats en santé ne seront pas obtenus tant que nous n'encouragerons pas les communautés à participer plus activement. Notre stratégie est de travailler avec les provinces et les communautés, en utilisant les ressources du gouvernement fédéral, afin de déterminer si nous pouvons établir un système de santé*

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[241] 20 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/27evb-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

> *dans lequel les communautés pourront jouer un rôle actif. Malgré nos compétences techniques, je ne pense pas que nous obtiendrons des bons résultats si nous ne réussissons pas à créer un système de santé qui serait perçu comme relevant de la communauté, soutenu par la communauté, et souvent mis en oeuvre par les membres de la communauté*[242].

Il a cependant ajouté que la souplesse était cruciale :

> *La participation des collectivités est essentielle à la réussite des programmes. Ceux-ci doivent aussi être suffisamment importants pour que l'on puisse assurer les services nécessaires. Il se peut donc qu'il faille des structures qui dépassent en taille et en capacité de nombreuses collectivités*[243].

M. Potter a également indiqué que Santé Canada souhaite une intégration accrue des services fédéraux et des services provinciaux de manière à réduire les doubles emplois et les chevauchements problématiques car :

> *La plupart des services que nous offrons sont dispensés par les Premières nations et les Inuits. Une partie du processus leur assure le soutien dont ils ont besoin pour jouer un rôle essentiel dans le système de soins de santé au Canada, qui est provincial ou territorial*[244].

Les peuples autochtones se sont dits inquiets d'être poussés dans l'arène provinciale (souvent sur base régionale). Ils ont indiqué qu'il leur était difficile de parvenir à une consultation et une participation complètes lorsque les programmes et services étaient identifiés, établis et fournis à l'échelle régionale.

Comme l'a expliqué Valerie Gideon :

> *Surtout dans les provinces où la plupart des décisions sont effectuées par des autorités régionales de la santé relativement indépendantes, les collectivités des Premières nations doivent veiller à forcer ces autorités à leur rendre compte du type de services qu'elles fournissent à leurs membres. Toutefois, le fait est que ces autorités n'ont pas la capacité de leur fournir des services. Un nombre très restreint d'autorités régionales*

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242 20 avril 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-e/13eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

243 Ian Potter, Sous-ministre adjoint, Direction générale de la santé des Premières nations et des Inuits, Santé Canada, lettre au sénateur Michael Kirby, président, Comité sénatorial permanent des Affaires sociales, des sciences et de la technologie, 7 février 2006, p.3.

244 20 avril 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/13eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

de la santé cherchent à établir des liens avec les collectivités des Premières nations[245].

Pour Onalee Randell, le financement régional n'appuie pas les programmes communautaires.

> *Il semble que nous traversons une période au cours de laquelle le financement du gouvernement fédéral n'est pas fondé sur la collectivité; il s'agit d'un financement régional qui implique des collectivités particulières. Ce financement est insuffisant pour le secteur de la santé mentale. Comment déterminer qu'une collectivité a besoin d'un programme de santé mentale? Serait-ce une collectivité où il n'y a pas eu de suicide ou une où il y en a eu quatre, cinq, six ou sept dans l'année*[246]*?*

14.7.2 Accommodement culturel

Les témoins ont demandé à avoir accès à des services et des soins de santé appropriés sur le plan culturel qui tiennent compte de la diversité culturelle interne, même au sein de chaque groupe. Ils ont demandé que le personnel chargé de la santé mentale ainsi que les autres fournisseurs de services, notamment les enseignants, les policiers et les chargés des services sociaux et des services à l'enfance reçoivent une formation en sensibilisation culturelle.

Elsie Bastien a déclaré que la compréhension et l'acceptation de la diversité des peuples autochtones étaient cruciales :

> *Les fournisseurs de services en santé mentale ne pourront créer un environnement culturel sûr pour les Autochtones que s'ils ont été formés pour comprendre et accepter le contexte culturel, linguistique, tribal, géographique, économique, politique et communautaire de diverses collectivités autochtones. La méconnaissance de l'importance de ces facteurs contextuels entraîne souvent la stigmatisation, de mauvais diagnostics et un traitement inapproprié*[247].

Tarry Hewitt, entre autres, a rappelé à plusieurs reprises l'importance des pratiques de guérison traditionnelles comme facteur important de progrès :

> *Les cercles de guérison, lorsqu'ils sont adaptés à la culture et dirigés par un Autochtone expérimenté, et dans notre cas, diplômé, sont plus que des « séances de groupe » à saveur indienne. Ils ont leurs racines dans les*

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[245] 20 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/27eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

[246] 20 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/27eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

[247] 9 juin 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/21evb-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

cérémonies et les traditions, et seuls les sages sont capables de les diriger[248].

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Bien que les témoins aient convenu qu'il fallait déléguer plus de pouvoirs aux collectivités autochtones pour concevoir des services sur mesure et encourager des solutions plus adaptées sur le plan culturel, ils ont reconnu qu'il y avait des obstacles. Tarry Hewitt a admis que des compétences traditionnelles d'appui :

> *[...] implique[nt], paradoxalement, de vaincre le préjugé non autochtone en faveur des traitements et des méthodes conventionnels, mais également le préjugé autochtone — conséquence de décennies d'intervention paternaliste — selon lequel les pratiques non autochtones seraient supérieures*[249].

Comme l'a signalé Sheila Levy, les traditions culturelles doivent s'intégrer aux réalités sociales :

> *Une rétrospective au travers d'une lentille rose n'a pas été bien utile. Les Inuits veulent le meilleur de chacun des deux mondes où ils vivent. Bien des Inuits avec qui j'ai travaillé et que je connais bien me l'ont affirmé. Ils veulent des méthodes fondées sur les preuves et des approches intégrées aux croyances inuites, à leur mode de vie et à leur culture*[250].

De toute évidence, les différences d'identité, de taille et de lieu géographique de chaque groupe doivent être prises en compte dans toute stratégie sur la santé mentale. Des représentants de Service correctionnel Canada ont dû expliquer si les programmes et services destinés aux délinquants autochtones tenaient compte des questions d'adaptation : par exemple, quelqu'un qui montre des signes de problèmes mentaux peut simplement avoir des difficultés d'adaptation sociale provenant du fait qu'il vient d'une culture et d'une région différentes. M. Michael Bettman, médecin à Service correctionnel Canada, a fait savoir que les questions étaient complexes et qu'il était difficile de trouver de bonnes solutions.

> *Si l'on pense à des traitements culturels spécifiques, et si l'on tient compte du monde rural par rapport au monde urbain, c'est encore plus compliqué. C'est pourquoi nous avons entrepris, non pas tant de recréer mais de construire à partir de la base, un bon nombre de nos*

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248 16 juin 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/22evc-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

249 16 juin 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/22cv-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

250 20 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/27evb-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

programmes pour les populations autochtones précisément — des programmes conçus par les peuples autochtones, souvent administrés par des membres des collectivités autochtones pour la population autochtone qui est surreprésentée dans notre système fédéral[251].

14.7.3 Égalité d'accès

De nombreux témoins ont réfuté avec insistance l'affirmation du gouvernement fédéral selon laquelle il y a des niveaux raisonnablement comparables de services pour les peuples autochtones dans tout le pays. Ils ont décrit le mélange de programmes et de services destinés aux peuples autochtones selon qu'ils sont Indiens, Métis, Inuits, et qu'ils vivent ou non dans des réserves, dans un milieu urbain du nord ou du sud, dans une province ou un territoire ou un autre. Certains ont ajouté que de fournir des services provinciaux comparables à ceux offerts à l'ensemble de la population à des personnes dont la santé et le bien-être est bien inférieur n'a pas de sens. Pour une meilleure comparabilité du niveau de santé réel, il faut que les programmes et services soient conçus expressément pour améliorer l'état de santé des peuples autochtones.

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Pour une meilleure comparabilité du niveau de santé réel, il faut que les programmes et services soient conçus expressément pour améliorer l'état de santé des peuples autochtones.

Donna Lyon a rappelé au Comité que les Métis sont généralement exclus :

> *Au sein du Centre métis, environ 30 p. 100 des Métis font partie du groupe cible de la population autochtone. Un grand nombre des initiatives destinées aux Premières nations ne vise pas les Métis et probablement pas non plus les Inuits. Les Métis ne sont pas non plus visés par le National Indian Health Board et ils n'ont pas accès au Programme national de lutte contre l'abus de l'alcool et des drogues chez les Autochtones*[252].

Même pour les Premières nations, il y a des problèmes de continuité selon que l'intéressé vit dans la réserve ou hors de la réserve et, dans ce cas, en ville. Irene Linklater a mentionné les exigences de résidence pour avoir droit de vivre en réserve :

> *Il y a ici un enjeu touchant le lieu de résidence, par exemple quelqu'un qui a dû passer trois mois à l'hôpital perd alors cet avantage et doit accéder aux services provinciaux. On peut faire face à d'autres complications, par exemple : si on doit s'en aller pour étudier ou pour*

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[251] 23 février 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/08ev-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

[252] 20 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/27eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

autre chose et qu'on doive ensuite recevoir des soins palliatifs, on ne peut revenir dans sa communauté, car les services médicaux ne comprennent pas l'allocation de fonds pouvant permettre à la personne de retourner chez elle pour mourir avec dignité[253].

Dans chaque champ de compétence, la prestation de services de santé à la population inuite varie selon le lieu de résidence. Les Inuits estiment que les services sont différents selon que les prestataires résident dans les territoires, où le gouvernement fédéral a toujours certaines compétences, ou vivent dans les provinces au sein desquelles il y a des populations inuites plus importantes comme le Québec ou Terre-Neuve et Labrador, où le gouvernement fédéral estime que la province est responsable, parce qu'ayant l'obligation de fournir les services dans le Nord. Comme l'a expliqué Onalee Randell :

La Direction générale de la santé des Premières nations et des Inuits offre des programmes de prévention et de promotion et, dans certains cas, des programmes de soins et de traitement limités à l'intention des collectivités inuites par l'entremise des deux gouvernements territoriaux. Ils sont offerts pour les Inuits vivant au Nunavut et à Inuvialuit par l'entremise de la Régie régionale de la santé et des services sociaux Nunavik du Québec et par l'intermédiaire de la Labrador Inuit Health Commission pour les Inuits du Labrador. À Nunavik, par exemple, dans le nord du Québec, une personne qui a besoin de services importants en santé mentale est transportée par Medivac dans un hôpital montréalais qui a conclu un partenariat ou une entente. En fait, un lit est réservé aux Inuits de Nunavik dans le réseau hospitalier de Montréal[254].

14.7.4 Recommandations

Le Comité reconnaît qu'il est nécessaire d'aborder la question sous un angle nouveau et d'avoir des idées novatrices menant à des programmes dotés d'objectifs clairs et de moyens précis de mesurer les progrès ou l'absence de progrès. Il se demande quels résultats ont eu les 200 millions de dollars alloués à un fonds pour l'adaptation des services de santé à l'intention des Autochtones, mis sur pied après la réunion spéciale de septembre 2004 du premier ministre, des premiers ministres et des chefs autochtones[255]. Ce fonds fédéral devrait permettre aux pouvoirs publics et aux

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253 1er juin 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/16evc-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

254 20 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/27eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

255 Gouvernement du Canada (septembre 2004), Engagement en matière de santé des Autochtones, http://www.hc-sc.gc.ca/ahc-asc/media/nr-cp/2004/2004_commit-engage_f.html.

collectivités de concevoir de nouvelles façons d'intégrer et d'adapter les services de santé existants afin de mieux répondre aux besoins de tous les peuples autochtones.

Le Comité convient qu'il est nécessaire de mettre en place un système transparent pour promouvoir le bien-être, non seulement des peuples des Premières nations et des Inuits, mais également de l'ensemble des peuples autochtones. Il sait que de nombreuses Premières nations ont accepté d'être responsables de la prestation directe des services de soins de santé. Il reconnaît également qu'il est nécessaire que la collectivité participe davantage à la conception et à l'application de tous les programmes et services visant les peuples autochtones et, dans la mesure du possible, ait le pouvoir et la compétence nécessaires relativement à ces programmes. Qui plus est, il estime que les programmes et services offerts à tous les peuples autochtones donneront de meilleurs résultats si les principes d'accommodement culturel et d'égalité d'accès sont respectés.

Le Comité ne s'attend pas à ce que le gouvernement fédéral fournisse tous les programmes et services nécessaires, mais il s'attend à ce qu'il veille à ce que ces derniers soient fournis, comme il en a la responsabilité. Le gouvernement fédéral peut y parvenir, soit directement en les fournissant, soit en fournissant aux provinces un financement expressément affecté aux peuples autochtones, qui soit calculé par habitant et selon leur état de santé. Quelle que soit l'autorité chargée de la prestation des programmes et services nécessaires, il est crucial que les pouvoirs soient clairement énoncés et les résultats suivis de près. Des mécanismes de contrôle adéquats et des mesures d'évaluation objectives doivent être mises en place.

Le Comité convient qu'il est nécessaire de mettre en place un système transparent pour promouvoir le bien-être, non seulement des peuples des Premières nations et des Inuits, mais également de l'ensemble des peuples autochtones.

Le Comité reconnaît que, compte tenu des arguments et des témoignages entendus à propos des responsabilités et des champs de compétence ainsi que de la prestation des services et de programmes, il s'ensuit logiquement qu'il faut mettre en place un modèle de gouvernance des affaires des peuples autochtones au Canada qui soit complètement différent. Ce nouveau modèle devrait tenir compte du fait que le moment est venu d'envisager sérieusement un mécanisme permettant aux peuples autochtones de participer à la prise de décisions les concernant. Le Comité sait aussi que ce nouveau modèle ne peut être une simple reconfiguration administrative. Son élaboration ne peut non plus être proposée dans le contexte d'un rapport dont le but premier est la santé mentale et le bien-être des Canadiens en général.

Le Comité estime que les programmes et services offerts à tous les peuples autochtones donneront de meilleurs résultats si les principes d'accommodement culturel et d'égalité d'accès sont respectés.

Le Comité n'estime donc pas judicieux de proposer une nouvelle entité ou structure fondée uniquement sur les témoignages qu'il a entendus pendant son étude sur la santé mentale. Mais il est préparé à appuyer la poursuite des travaux sur les questions de gouvernance et d'administration pour les peuples autochtones. Il reconnaît en particulier la nécessité d'une

Le Comité n'estime donc pas judicieux de proposer une nouvelle entité ou structure fondée uniquement sur les témoignages qu'il a entendus pendant son étude sur la santé mentale.

plus grande autonomie pour les peuples autochtones sur le plan de la conception et de la prestation des programmes et services visant à répondre aux besoins qu'ils auront dégagés.

Pour le moment, le Comité recommande donc :

96.	**Que le gouvernement du Canada travaille en étroite collaboration avec les provinces et territoires et les représentants des diverses collectivités autochtones à la mise sur pied des programmes et services jugés nécessaires par les peuples autochtones.** **Que les critères de conception et de prestation des programmes et services jugés nécessaires tiennent compte du fait qu'il est important d'accroître la participation de la collectivité et d'assurer l'accommodement culturel et l'égalité d'accès.** **Que tout mode de prestation de ces programmes et services comporte un mécanisme permanent de surveillance et d'évaluation par le public des résultats qu'aura obtenus l'organisme qui en assure le financement.** **Que les critères de financement et de reddition de comptes soient rendus publics.**

14.8 MESURES PARTICULIÈRES

14.8.1 Reconduction de la Fondation autochtone de guérison

De nombreux témoins ont insisté sur la nécessité de miser sur les efforts de la Fondation autochtone de guérison et appelé à sa reconduction à long terme. Cette fondation a été établie en 1998 et dotée d'un mandat de 10 ans consistant à régler les questions liées à la violence physique et aux sévices sexuels perpétrés dans les pensionnats[256]. Elle occupe une place particulière en tant que premier organisme autochtone national représentant tous les groupes travaillant à des projets décidés à l'initiative des Autochtones et mis en place au niveau de la collectivité. Selon Gail Valaskakis, elle a joué un rôle critique puisqu'elle a établi des partenariats, déterminé et comblé les écarts au niveau des services et fait participer les survivants et ceux qui subissent les répercussions intergénérationnelles[257].

Des représentants des Premières nations et des Inuits ont indiqué qu'il fallait renouveler à long terme le financement de la Fondation de manière à élargir et à maintenir les projets de guérison communautaires. Pour Shawn Atleo, chef A-in-chut, chef régional de la Colombie-Britannique, le financement des efforts de guérison au niveau de la collectivité sont cruciaux pour accroître le bien-être émotionnel dans sa collectivité :

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256 Fondation autochtone de guérison, http://www.ahf.ca/f_AboutUs.aspx.

257 20 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/27eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

> *Durant les années 1990, nous avons assisté à une baisse des tentatives de suicide et des suicides parmi les Nuu-chah-nulth. Même si nous ne pouvons pas indiquer un seul facteur, je sais que le travail de la Fondation autochtone de guérison a été extraordinaire pour notre peuple. La Fondation a permis la création et la prestation de services de guérison fondées sur les collectivités*[258].

Pour les Inuits, qui ont adopté le processus relativement tard, les programmes mis en place par la Fondation ont comblé un besoin :

> *Les Inuits qui ont examiné le programme de la Fondation autochtone de guérison ont conclu qu'il fallait en élargir la portée et qu'il ne souligne pas seulement les pensionnats et leur effet négatif en termes d'abus, mais aussi l'effet négatif lié à la perte de la langue, la perte culturelle et la perte des compétences parentales. Ceux qui ont fait cette recommandation ont déclaré ne pas avoir subi d'abus aux pensionnats; ils croient que les pensionnats ont été une expérience positive. Toutefois, ils ne parlent pas leur langue et ils éprouvent un sentiment de perte de culture. — Onalee Randell*[259]

Le financement de la Fondation cesse en 2007 et, pour de nombreux groupes, cela représente un autre exemple de l'instabilité qui découle du financement à court terme. Lorsque les collectivités se seront dotées des capacités nécessaires pour demander un financement par l'entremise de la Fondation, celui-ci sera épuisé :

> *Durant les trois premières années de ce financement, les collectivités ont essayé de déterminer leurs besoins et leur application et même d'avoir recours à de l'assistance pour rédiger des propositions, assistance qui a été fournie par la Fondation autochtone de guérison. Quand finalement des initiatives ayant des échéanciers de trois à cinq ans sont mises en place dans les collectivités, le financement a cessé. Il est peu probable que des employés quittent un emploi permanent pour travailler dans un projet ne pouvant durer que deux ans; il est donc difficile de recruter du personnel qualifié.— Onalee Randell*[260].

Gail Valaskakis a confirmé que les Inuits n'ont accédé aux programmes de la Fondation autochtone de guérison que relativement tard. Elle a également noté :

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258 20 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/27eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

259 20 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/27eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

260 20 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/27eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

> *Il a été encore plus ardu d'atteindre les Métis, qui constituent un groupe cible. Il a aussi été difficile d'atteindre un grand nombre de personnes qui sont invisibles à nos yeux, comme les sans-abri et les détenus*[261] …

Mme Valaskakis s'est appuyée sur les données de deux études portant sur le coût des violences et la valeur de la guérison pour prouver que « la guérison est rentable et efficace sur le plan individuel et social ». Selon l'Étude canadienne sur l'incidence des signalements de cas de violence et de négligence envers les enfants, la violence faite aux enfants est extrêmement coûteuse et « la société canadienne paie environ 440 millions de dollars par année en services correctionnels, en services sociaux et en services d'éducation spéciale et de santé »[262].

La seconde étude citée par Mme Valaskakis portait sur la guérison au regard de l'incarcération dans la Hollow Water Reserve. Elle montrait que la guérison est plus rentable et efficace que l'incarcération et, en fait, en diminue l'incidence :

> *Pour chaque 2 $ consacré au programme communautaire des cercles de guérison, les gouvernements fédéral et provinciaux économisent de 6 $ à 16 $ en frais d'incarcération. Il s'agit d'une estimation prudente, calculée en maintenant le coût du système constant et en ajoutant le coût d'un détenu*[263].

On estime que la Fondation autochtone de guérison fournit le type d'approche intégrée qui a de meilleures chances de réussir que le modèle compartimenté actuellement en cours. Comme en a témoigné Gail Valaskakis :

> *Jusqu'ici, la Fondation autochtone de guérison a investi 437 millions de dollars dans des projets communautaires de tous types : il peut s'agir de projets de sensibilisation et de prévention, de véritables services de guérison et de ressourcement, et de services de guérison de longue durée dans des centres de traitement des traumatismes ou en vertu de programmes de traitement des dépendances*[264].

Elle a appelé à un appui à long terme de la Fondation autochtone de guérison :

> *La somme de 600 millions de dollars permettrait d'appuyer une stratégie de guérison s'échelonnant sur 30 ans, en tenant compte d'un taux d'inflation de 2,5 p. 100. En outre, cet investissement entraînerait un*

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261 20 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/27eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

262 20 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/27eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

263 20 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/27eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

264 21 juin 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/23evb-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

rendement de 5 p. 100. Ainsi, 28,7 millions de dollars par année seraient disponibles pour financer des projets dans les communautés. Cela signifie qu'au bout de 30 ans, la Fondation autochtone de guérison aurait investi 1,2 milliard de dollars dans la guérison[265].

Le Comité félicite la Fondation autochtone de guérison pour le travail que celle-ci a effectué et est d'accord avec tous ceux qui appellent à un engagement à long terme envers son travail. Il reconnaît la nécessité de continuer à s'occuper des séquelles des violences et des incidences intergénérationnelles, entre autres, des blessures sociales, psychologiques, culturelles et spirituelles. Il appuie les objectifs que sont la reconnaissance, le redressement, la guérison et la réconciliation.

Le Comité recommande;

97	**Que le gouvernement du Canada renouvelle le mandat de la Fondation autochtone de guérison et en assure le financement pendant trois autres années.** **Qu'en priorité la Commission canadienne de la santé mentale (voir le Chapitre 16) et son Comité consultatif autochtone entreprennent une évaluation de l'efficience et de l'efficacité de la Fondation autochtone de guérison.** **Que les résultats de l'évaluation s'assortissent de recommandations concernant l'avenir de la Fondation autochtone de guérison et soient rendus publics.**

14.8.2 Accroissement des ressources humaines en santé

Tous les témoins ont reconnu que la santé mentale, la prévention et le traitement des maladies mentales dépendent de soins intégrés et interdisciplinaires assurés par divers fournisseurs de soins de santé. Dans les collectivités autochtones, la pénurie aigüe de médecins généralistes, d'infirmiers, de psychiatres, de psychologues, de travailleurs sociaux et d'autres professionnels de la santé nuit gravement à la prestation de soins et de services appropriés.

Beaucoup ont insisté sur la nécessité d'avoir des professionnels de la santé mentale qui sont eux-mêmes autochtones, ou, du moins, qui connaissent les cultures autochtones. les fournisseurs de soins qui sont autochtones peuvent compenser les préjugés culturels qui peuvent influer sur le diagnostic.

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[265] 20 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/27eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

Arnold Devlin a expliqué comment les psychiatres formés dans une autre culture et ayant des vécus différents ont réagi face aux peuples autochtones du Nord de l'Ontario :

> *Jadis, les psychiatres de la région Nishnawbe-Aski étaient formés en Écosse et en Angleterre. Ils débarquaient dans la région fraîchement diplômés de l'Université de Toronto. Ils diagnostiquaient chez les gens de multiples troubles de la personnalité et des maladies mentales exotiques. Je me souviens d'avoir jasé, une fois, avec une dame qui venait de voir le psychiatre et je lui ai demandé ce qu'elle lui avait dit. Elle m'a répondu qu'elle lui avait simplement raconté sa vie et qu'il lui avait prescrit des médicaments. Voilà la réalité et, souvent, la conception du monde, le sens des valeurs et les croyances sont très différents, de sorte que le psychiatre n'y voit que du feu et ne comprends pas ce que vit la personne*[266].

Selon Rob Wipond, les fournisseurs de soins qui sont autochtones peuvent compenser les préjugés culturels qui peuvent influer sur le diagnostic. Réfutant l'opinion selon laquelle les collectivités autochtones souffrent davantage de troubles mentaux que le reste de la population, il a affirmé :

> *Pourtant, d'innombrables travaux de recherche ont conclu que les différences au chapitre de la culture, du mode de vie et de la spiritualité représentent des facteurs fondamentaux dans les diagnostics posés et les traitements imposés. Si vous vous mettez à voir des dieux et des démons, et si vous croyez que vous êtes sur le point de connaître un éveil mystique, il serait fort surprenant qu'un psychiatre vous accompagne dans votre exploration. Il vous qualifiera de sujet « délirant », sans doute de « schizophrène », et il vous tranquillisera*[267].

Le nombre de travailleurs autochtones qui oeuvrent actuellement dans le domaine de la santé mentale et leurs préoccupations particulières n'ont pas été entièrement quantifiées. Par exemple, une psychiatre autochtone, Cornelia Wieman, qui était retournée dans sa réserve des Six-Nations pour y pratiquer la médecine, s'est rendu compte que la collectivité n'avait pas les fonds nécessaires pour lui verser un salaire compatible avec sa formation et son expertise.

Plusieurs témoins ont insisté sur la nécessité de répondre de façon novatrice à la pénurie d'Autochtones dans le domaine de la santé mentale.

Arthur W. Blue, médecin, a fait remarquer que Native Psychologists of Canada est un petit organisme comptant moins de 20 membres. Il estime nécessaire d'avoir un établissement de soutien chargé de former des psychologues

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[266] 20 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/27evb-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

[267] 6 juin 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/18eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

cliniques autochtones et, ainsi, obtenir les mêmes résultats que le programme d'accès des Autochtones, grâce auquel on est passé de 51 à 250 médecins autochtones en 20 ans. Il a insisté sur l'importance du rôle des psychologues :

> *Ce n'est pas seulement que le traitement, mais aussi la prévention. Non seulement font-ils de la psychométrie, de la psychothérapie, de la psychothérapie de groupes, du traitement des abus, tant physiques que de substances toxiques, mais ce sont les professionnels de la santé mentale les mieux éduqués qu'aie le Canada, et ils devraient travailler main dans la main avec les travailleurs de la santé mentale, les travailleurs sociaux, les médecins et les conseils de bande*[268].

Bon nombre d'Autochtones ne réussissent pas à poursuivre des études et à faire carrière comme travailleurs sociaux. Plusieurs témoins ont insisté sur la nécessité de répondre de façon novatrice à la pénurie d'Autochtones dans le domaine de la santé mentale. Tarry Hewitt a décrit le programme de formation juridique destiné à 10 étudiants du Nunavut offert par la Akitsiraq Law School, en collaboration avec l'Université de l'école Victoria Law, l'Université d'Ottawa, le gouvernement du Canada et le gouvernement du Nunavut. Elle a également mentionné la collaboration de l'Université du Cap-Breton et des collectivités des Premières nations en Nouvelle-Écosse dans le but d'amener l'université dans les collectivités :

Le Comité estime cependant qu'il faut s'efforcer tout particulièrement d'accroître le nombre d'Autochtones qui poursuivent des carrières dans le domaine des soins de la santé, en particulier de la santé mentale. Il faut de toute urgence mettre en place des approches qui tiennent compte de la culture de manière à pouvoir former et conserver des psychiatres, des psychologues, des infirmiers en santé mentale, des travailleurs sociaux autochtones, entre autres professionnels de la santé.

> *Les avantages sont évidents : les étudiants peuvent poursuivre leurs études postsecondaires sans avoir à quitter leur famille ou à abandonner leurs responsabilités familiales, dans un environnement familier et moins intimidant. De telles expériences conduisent à une augmentation du taux de persévérance scolaire. Les établissements d'enseignement profitent de ces partenariats pour donner l'occasion aux professeurs invités de mieux connaître les collectivités et les coutumes des Premières nations*[269].

Debbie Dedam-Montour, directrice exécutive, National Indian and Inuit Community Health Representatives Organization, a signalé que la formation d'un représentant en santé communautaire (REC) avait changé dans le cadre du processus de transfert de la santé et, au lieu d'être offerte par Santé Canada, se trouvait sous l'égide d'une bande. Elle a précisé : « Certains collèges, comme le Collège Portage, offrent un programme des représentants de la santé communautaire. L'Alberta et le Manitoba offrent aussi des cours mais pas dans le cadre

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[268] 20 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/27evb-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

[269] 16 juin 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/22evc-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

d'un programme structuré. »[270] Le but poursuivi actuellement est d'établir des programmes de formation en compétences essentielles pour les REC dans chacune des provinces.

La question de l'accréditation, de l'établissement des qualifications de guérisseur, a également été abordée par Tarry Hewitt :

> *Les collectivités autochtones disposent d'hommes et de femmes capables de continuer à guérir traditionnellement et toujours prêts à s'inspirer des anciens et des guérisseurs et guérisseuses. Ces hommes et ces femmes pourraient devenir d'excellents facilitateurs des cercles de guérison et autres méthodes de guérison traditionnelles. Les collectivités autochtones disposent déjà des structures qui permettraient d'étudier en détail la capacité reconnue de ces guérisseurs aux services incommensurables*[271].

Ce processus est important pour les guérisseurs traditionnels qui demandent un financement à Santé Canada en tant que travailleurs de la santé dans les collectivités inuites et des Premières nations. Selon Ian Potter, il faut un système de normalisation :

> *Nous avons certaines limites à l'égard du financement de la médecine traditionnelle parce qu'aucun système ne définit qui sont les spécialistes en médecine traditionnelle. Dans d'autres pays — et c'est que nous avons essayé d'encourager les Premières nations et les Inuits du Canada à envisager — les personnes qui pratiquent la médecine traditionnelle se sont regroupées afin de reconnaître les fournisseurs officiels de ces services. Jusqu'à présent, nous n'y sommes pas arrivés. Cela soulève des problèmes en matière de responsabilité; si nous payons pour quelque chose, nous devons savoir de quoi il s'agit*[272].

Le Comité est conscient des progrès réalisés depuis quelques dizaines d'années dans le domaine des ressources humaines en santé autochtone. Il connaît les efforts du Programme des carrières de la santé pour Indiens et Inuits et de la Fondation nationale des réalisations autochtones. Il reconnaît que l'annonce du versement de 100 millions de dollars à l'Initiative relative aux ressources humaines en santé qui a fait suite à la réunion spéciale du premier ministre, des premiers ministres et des chefs autochtones en septembre 2004 constitue un pas dans la bonne voie.

Le Comité estime cependant qu'il faut s'efforcer tout particulièrement d'accroître le nombre d'Autochtones qui poursuivent des carrières dans le domaine des soins de la santé, en particulier de la santé mentale. Il faut de toute urgence mettre en place des approches qui tiennent compte de la culture de manière à pouvoir former et conserver des psychiatres, des

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[270] 20 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/27evb-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

[271] 16 juin 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/22evc-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

[272] 20 avril 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/13eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

psychologues, des infirmiers en santé mentale, des travailleurs sociaux autochtones, entre autres professionnels de la santé.

Le Comité recommande :

Que le gouvernement du Canada travaille avec les provinces et les universités et collèges à l'établissement de cibles claires concernant les ressources autochtones en santé humaine.

Que le gouvernement du Canada finance des mesures visant à faciliter spécifiquement l'inscription des Autochtones à des programmes d'études menant à une carrière dans le secteur de la santé mentale.

Que le gouvernement du Canada accroisse son appui financier et social aux étudiants autochtones qui poursuivent ce type d'études.

14.8.3 Prévention du suicide

Au Canada, le taux de suicide est beaucoup plus important chez les Autochtones que pour l'ensemble de la population. En 1995, la Commission royale sur les peuples autochtones a estimé que ce taux était en moyenne trois fois plus haut chez les Autochtones, quelque soit leur groupe d'âge, que dans la population non autochtone. Pour les Indiens inscrits, il était de 3,3 fois supérieur à la moyenne nationale et pour les Inuits, de 3,9 fois. Chez les Autochtones ayant entre 10 et 19 ans, ce taux était de cinq à six fois plus élevé que chez leurs pairs non autochtones[273].

Dans les régions inuites, les taux de suicide sont de 11 fois supérieurs à la moyenne nationale.

On estime essentiel, aux fins du dépistage précoce et de l'intervention efficace, d'assurer une surveillance, de réunir des données puis de les analyser, d'appliquer ses connaissances et de diffuser une information exacte.

La prévention du suicide chez les jeunes est perçue comme un domaine dans lequel il faut agir de toute urgence.

D'après certains témoins, ces statistiques ne donnent pas une idée exacte de la situation, car bien des cas ne sont pas déclarés. Pour Debbie Dedam-Montour, les statistiques ne tiennent pas compte en général des tentatives de suicide déclarées comme des morts accidentelles ni les tentatives n'ayant pas abouti. Des témoins ont affirmé que les taux de suicide signalés étaient beaucoup plus élevés en 2005. Larry Gordon a notamment mentionné que, dans les régions inuites, les taux de suicide sont de 11 fois supérieurs à la moyenne nationale[274]. James Morris, porte-parole des 32 Premières

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[273] Commission royale sur les peuples autochtones, « Choisir la vie : Un rapport spécial sur le suicide chez les autochtones » (1995)

[274] 21 avril 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/13evb-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

nations isolées desservies par l'Autorité sanitaire des Premières nations de Sioux Lookout dans le nord de l'Ontario, a signalé l'extrême fréquence des suicides dans sa région.

> *Le taux national de suicide chez les jeunes au Canada est de 0 à 14,9 par 100 000 habitants. Dans certaines de nos collectivités, c'est 42,5 par 100 000 habitants. Le taux de suicide est de 398 par 100 000 habitants dans le groupe d'âge de 15 à 19 ans. La moyenne nationale est de 12,9 par 100 000 habitants*[275].

Pour tous les groupes, on estime essentiel, aux fins du dépistage précoce et de l'intervention efficace, d'assurer une surveillance, de réunir des données puis de les analyser, d'appliquer ses connaissances et de diffuser une information exacte. Onalee Randell a expliqué :

> *Le manque de données spécifiques aux Inuits les empêche de travailler ensemble dans toutes les régions du Canada. Des données sur la fréquence des suicides au niveau des collectivités sont fournies par des conseils régionaux. Il n'existe pas de système national d'enregistrement des suicides chez les Inuits. Les renseignements proviennent des collectivités. Les niveaux de données sur le taux de tentatives ou le taux de maladie mentale sont différents*[276].

La prévention du suicide chez les jeunes est perçue comme un domaine dans lequel il faut agir de toute urgence. Pour Jason Whitford :

> *Par ailleurs, parmi les 300 personnes environ que nous avons rencontrées pour parler de prévention du suicide, environ 95 p. 100 avaient été directement touchées dans leur famille ou parmi leurs amis.*
>
> *Par contre, dans la société en général, c'est le contraire. Le suicide touche probablement 10 p. 100 de la population générale par la perte d'un membre de la famille ou d'un ami proche*[277].

Bien des facteurs contribuent au suicide. Selon le rapport de 1995 de la Commission royale sur les peuples autochtones, les principaux facteurs de risque de suicide chez les peuples autochtones sont le contexte situationnel, les facteurs socio-économiques et

La majorité des témoins ont expliqué que le suicide était l'aboutissement d'une série de problèmes tout à fait fondamentaux, qui s'inscrivent tous dans un large éventail de déterminants de la santé.

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275 20 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/27evb-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

276 20 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/27evb-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

277 31 mai 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/16evb-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

les tensions d'ordre culturel. La présence de maladies mentales liées à des facteurs psychobiologiques, comme l'anxiété et la schizophrénie, est moins documentée chez les autochtones que dans d'autres groupes[278]. Arnold Devlin a répété ce point :

> *Je ne pense pas que le problème du suicide chez les Premières nations puisse être attribué uniquement à la maladie mentale. Je crois que la dépression et l'abus d'alcool ou de drogues font partie des causes, mais il y a également d'autres facteurs qui contribuent au sentiment de désespoir, qui lui, mène au suicide.*
>
> *L'enfant de 10 ans ou le jeune de 14 ans qui se suicide ne souffre pas d'une maladie mentale. Il a plutôt baissé les bras. Si nous examinons le problème uniquement sous l'angle de la maladie mentale, on perd de vue les autres causes de nature historique*[279].

On a abordé la nécessité d'intégrer les programmes et services de santé mentale et physique et, ainsi, de moins cloisonner les services et morceler les enjeux.

La majorité des témoins ont expliqué que le suicide était l'aboutissement d'une série de problèmes tout à fait fondamentaux, qui s'inscrivent tous dans un large éventail de déterminants de la santé. Ils ont précisé qu'il faudrait consacrer les ressources à un stade précoce afin de prévenir ou d'atténuer les problèmes qui contribuent à ces forts taux de suicide dans les collectivités autochtones. Ron Evans, chef de la nation crie de Norway House, a dit avec insistance :

> *Nous ne voulons pas faire la liste de tous les malheurs qu'ont connus nos peuples. Nous voulons que vous sachiez que nos peuples continuent à souffrir de ce mal que nos anciens et nos guérisseurs imputent à des traumatismes non résolus et transmis de génération en génération. Certains voient dans cette situation une sorte de traumatisme historique ou de deuil collectif qui se manifeste par la fréquence disproportionnée de cas d'alcoolisme, de toxicomanie, de dépendance au jeu et d'autres formes d'accoutumance, ainsi que dans des taux élevés de suicide, en particulier chez les jeunes*[280].

James Morris, directeur exécutif, Nodin Counselling Services, a fait observer à propos de certaines causes du suicide :

> *L'oppression et la colonisation, qui remontent à une centaine d'années, font partie de ces causes. Quiconque n'a pas vécu la colonisation ou*

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278 Commission royale sur les peoples autochtones (1995), « Choisir la vie : un rapport spécial sur le suicide chez les Autochtones ».

279 20 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/27evb-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

280 31 mai 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/27evb-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

l'oppression ne peut comprendre le problème. Nous, nous le comprenons, car nous les avons vécues.

Les pensionnats constituent aussi une partie du problème. De même, si vous n'avez pas été une victime des pensionnats, vous ne pouvez pas comprendre parce que vous ne connaissez pas le sentiment. C'est comme dans les cas du racisme. Le racisme est partout, mais si vous n'en avez jamais été victime, vous ne savez pas ce que c'est. Si cela ne vous concerne pas, vous n'êtes pas affecté et vous ne réagissez pas. Lorsque vous êtes témoin de racisme, vous ne faites rien parce que cela ne vous touche pas. Nous, nous sommes confrontés au racisme tous les jours, partout. C'est une réalité[281].

On a abordé la nécessité d'intégrer les programmes et services de santé mentale et physique et, ainsi, de moins cloisonner les services et morceler les enjeux. Sheila Levy a souligné que le suicide ne peut être distingué d'autres problèmes.

Le Comité est extrêmement préoccupé par les forts taux de suicide chez les peuples autochtones.

On a tendance à voir le suicide, la violence, les toxicomanies, les abus et la santé mentale comme des problèmes distincts les uns des autres. Les enveloppes budgétaires distinctes sont attribuées à chacun d'eux, alors que nous devrions d'abord régler les éléments communs sous-jacents de ces enjeux[282].

Le Comité désire que soient prises des mesures concrètes afin de réduire l'effrayant taux de suicide des enfants et des adolescents autochtones.

Onalee Randell s'est dite en faveur d'une plus grande intégration des programmes au niveau communautaire de manière à obtenir de meilleurs résultats :

Les toxicomanes qui vont suivre des traitements reviennent dans leurs collectivités sans que les services de santé ou les services sociaux aient été avisés ni de leur retour ni du suivi des résultats de leur traitement. Les enfants et les jeunes qui ont tenté de se suicider sont envoyés à l'extérieur de leurs collectivités pour recevoir des soins et reviennent sans suivi et, dans certains cas, sans que les infirmières des centres de santé qui les ont elles-mêmes envoyés soient tenus informées du retour de ces jeunes[283].

Le Comité est extrêmement préoccupé par les forts taux de suicide chez les peuples autochtones. Cela fait plus de dix ans déjà que la Commission royale sur les peuples

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281 20 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/27evb-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

282 20 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/27evb-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

283 20 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/27eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

autochtones a signalé ce phénomène et ses effets dévastateurs sur les collectivités autochtones. Loin de s'améliorer, la situation s'est en fait dégradée, au dire des témoins.

Le Comité fait observer qu'à partir de 2005 Santé Canada devrait accorder 65 millions de dollars sur cinq ans à une nouvelle Stratégie nationale de prévention du suicide chez les jeunes Autochtones; le ministère y versera 15 millions de dollars par an entre la deuxième et la cinquième année. Des fonds sont destinés aux Premières nations vivant dans des réserves et aux Inuits afin d'appuyer les collectivités menacées, par le biais de mécanismes de stabilisation et d'intervention en cas de crise. Certains fonds supplémentaires aux fins de recherche seront consacrés aux jeunes autochtones hors des réserves.

Le Comité estime que la Commission canadienne de la santé mentale proposée aura un rôle à jouer dans l'élaboration de protocoles et de normes cohérentes, dans la compréhension des facteurs de risque et dans l'organisation d'un programme national de recherche sur le suicide. Mais, surtout, il désire que soient prises des mesures concrètes afin de réduire l'effrayant taux de suicide des enfants et des adolescents autochtones. Il juge que c'est la Commission canadienne de la santé mentale qui serait la mieux à même de s'acquitter de cette entreprise, en étroite collaboration avec d'autres organismes, comme les Instituts de recherche en santé du Canada et l'Institut canadien d'information sur la santé.

Conscient du besoin criant de mesures immédiates qui soient adaptées à la culture des intéressés, le Comité recommande :

99	**Qu'en priorité la Commission canadienne de la santé mentale (voir le Chapitre 16) établisse des mesures visant à réduire les taux de suicide alarmants chez les peuples autochtones.** **Que l'établissement de ces mesures fasse partie de son action prioritaire en matière de stratégie de guérison et de bien-être pour les autochtones.** **Que le gouvernement du Canada mette sur pied un fonds conçu expressément pour lutter contre le suicide qui tienne compte des besoins distincts de chaque groupe d'Autochtones.** **Que ce fonds comprenne des affectations particulières pour que l'on puisse mettre en place toutes les mesures que la Commission canadienne de la santé mentale aura prévues, pour que les Instituts de recherche en santé du Canada puissent intensifier leurs recherches sur le sujet et pour que l'Institut canadien d'information sur la santé, en collaboration avec l'Organisation nationale de la santé autochtone, puisse réunir des données précises sur la question.**

14.8.4 Réduction de l'alcoolisme et de la toxicomanie

Les témoins ont expliqué les liens qui existent entre l'alcool et la toxicomanie et les autres problèmes sociaux. James Morris a répété que « tous ces problèmes sociaux, soit le suicide, l'abus sexuel, la violence familiale, l'abus d'alcool et de drogues, traduisent des problèmes plus profonds »[284]. Debbie Dedam-Montour a estimé quant à elle qu'« il y a cette vaste expression de « violence familiale », qui désigne la violence sexuelle, physique, émotionnelle et psychologique, et la négligence. Cette violence a eu un effet d'entraînement, parce qu'elle amène les victimes à s'automédicamenter par l'alcool ou par toutes sortes de substances nocives, et à séjourner dans des établissements correctionnels »[285].

L'Assemblée des Premières nations estimait elle aussi nécessaire de mettre sur pied un financement approprié pour créer et gérer des installations de traitement régionales pour tous ceux qui abusent de solvants et les toxicomanes.

Les collectivités inuites ont besoin de programmes axés en particulier sur l'alcoolisme et la toxicomanie qui soient adaptés à la culture des intéressés et fassent appel à des modèles d'abstinence et de réduction des préjudices.

La corrélation entre alcoolisme, toxicomanie et suicide, entre autres problèmes sociaux, exige une approche concertée en matière d'hygiène publique.

L'Assemblée des Premières nations estimait elle aussi nécessaire de mettre sur pied un financement approprié pour créer et gérer des installations de traitement régionales pour tous ceux qui abusent de solvants et les toxicomanes. Valerie Gideon a expliqué les propositions au Comité :

> *... le développement ou la création de nouveaux centres dont les traitements ne se limiteront pas à ceux de l'alcoolisme, par exemple, ou des drogues les plus populaires. Un tel mandat leur permettra d'étudier certaines nouvelles drogues, comme la méthamphétamine [en cristaux] par exemple, qui joue un rôle capital au plan de la santé mentale et des suicides dans nos collectivités*[286].

Donna Lyon a signalé que Santé Canada ne finance pas suffisamment la lutte contre la toxicomanie :

> *Les listes d'attente pour le counselling sont longues et le financement pour le transport des patients est insuffisant. La plus grosse partie du*

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[284] 20 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/27evb-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

[285] 20 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/27evb-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

[286] 20 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/27eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

financement sert en priorité aux soins actifs et aux interventions d'urgence à court terme[287].

Les collectivités inuites ont besoin de programmes axés en particulier sur l'alcoolisme et la toxicomanie qui soient adaptés à la culture des intéressés et fassent appel à des modèles d'abstinence et de réduction des préjudices :

> *Il faut augmenter le nombre de conseillers inuits en toxicomanie et en intervention précoce. Nous avons besoin de services pour assurer la post-cure et le suivi dans les collectivités. Les jeunes ne sont plus heureux de suivre un traitement de six mois dans un établissement et revenir à la maison pour retrouver la même situation; le même logement surpeuplé, les mêmes coûts élevés et aucun soutien.— Onalee Randell*[288].

Le Comité est d'accord avec le message selon lequel la corrélation entre alcoolisme, toxicomanie et suicide, entre autres problèmes sociaux, exige une approche concertée en matière d'hygiène publique. Il est essentiel d'évaluer avec soin les meilleurs moyens d'obtenir des résultats concrets. Il est donc d'une extrême importance que la Commission canadienne de la santé mentale collabore très étroitement avec d'autres organismes comme les Instituts de recherche en santé du Canada et le Centre canadien de lutte contre l'alcoolisme et les toxicomanies.

Le Comité recommande :

100	**Que la Commission canadienne de la santé mentale (voir le Chapitre 16) établisse des mesures visant à réduire les taux alarmants d'alcoolisme et de toxicomanie chez les peuples autochtones.** **Que l'établissement de ces mesures fasse partie de son programme prioritaire visant une stratégie de guérison et de bien-être des Autochtones.** **Que le gouvernement du Canada établisse un fonds affecté exclusivement à la lutte contre les toxicomanies qui tienne compte des besoins distincts de chaque groupe d'Autochtones.**

[287] 20 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/27eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

[288] 20 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/27eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

Que ce fonds comprenne des affectations particulières pour que l'on puisse mettre en place toutes les mesures que la Commission canadienne de la santé mentale aura prévues, pour que les Instituts de recherche en santé du Canada puissent intensifier leurs recherches sur le sujet et pour que le Centre canadien de lutte contre l'alcoolisme et les toxicomanies, en collaboration avec l'Organisation nationale de la santé autochtone, puisse réunir des données précises sur la question.

14.9 ÉVALUER LES DONNÉES ET LE FINANCEMENT

Il est primordial pour qu'une stratégie réussisse que l'on dispose à la fois des fonds nécessaires et des données sur le déroulement du processus. L'argent ne suffira pas à redresser le piètre état de santé des peuples autochtones, bien qu'il faille indubitablement dépenser davantage dans ce domaine. Il est crucial de savoir exactement comment les deniers publics sont actuellement dépensés et les résultats que cela donne. Il faut par ailleurs adopter de nouvelles méthodes de collecte de données, à la fois pour améliorer les soins et pour documenter les nouvelles approches sur la façon de répartir au mieux les fonds pour obtenir les meilleurs résultats possibles.

14.9.1 Des données élargies

Tout plan d'action ou stratégie efficace se fonde sur des données. Depuis 10 ans, de nombreux rapports — de ceux provenant de la Commission royale sur les peuples autochtones à ceux produits après la récente rencontre des premiers ministres et des chefs autochtones — prônent l'élaboration d'un cadre de collecte et de déclaration de renseignements comparables pour tous les groupes autochtones.

Il n'existe aucune collecte régulière de données sur la fréquence des maladies mentales et des toxicomanies chez les Autochtones.

La plus importante source de données sur les personnes handicapées au Canada, l'Enquête sur la participation et les limitations d'activités EPLA, ne fournit aucun renseignement propre aux peuples autochtones.

Bien que le gouvernement du Canada se soit engagé, dans le cadre de la Table ronde Canada-Peuples autochtones de 2004, à produire un rapport sur la situation des Autochtones, il n'existe aucune collecte régulière de données sur la fréquence des maladies mentales et des toxicomanies chez ces derniers. Des témoins ont reconnu que les ministères fédéraux ont de la difficulté à obtenir des données complètes sur la santé mentale de tous les peuples autochtones. Affaires indiennes et du Nord Canada et Santé Canada, ainsi que le Service correctionnel du Canada offrent des programmes et services particuliers aux Premières nations et aux Inuits, mais les analyses de données concernant ces groupes sont limitées.

Les témoins ont demandé que des données de référence soient constituées à partir desquelles il serait possible d'établir des cibles précises.

À Développement social Canada, la plus importante source de données sur les personnes handicapées au Canada, l'Enquête sur la participation et les limitations d'activités EPLA, ne fournit aucun renseignement propre aux peuples autochtones. Tout en laissant entendre que les taux d'incapacité — y compris sur le plan mental — pourraient être plus élevés chez les peuples autochtones que dans le reste de la population, Cecilia Muir, directrice générale, Bureau de la condition des personnes handicapées, a expliqué :

> *Toutefois, nous ne disposons pas de données précises. J'ai parlé de la taille de la population, mais cela ne se rapporte pas précisément au groupe démographique autochtone. Ce dernier n'a pas fait l'objet d'un suréchantillonage, et nous n'avons donc pas de renseignements plus poussés sur les incidents qui y surviennent*[289].

Les témoins ont insisté sur la nécessité d'établir des données propres à chaque groupe.

Des témoins ont insisté sur la nécessité d'améliorer la qualité des données, pour que l'on puisse prendre des décisions informées en matière de bien-être. Ils ont demandé que des données de référence soient constituées à partir desquelles il serait possible d'établir des cibles précises. Ils ont demandé plus de reddition de comptes et de transparence de la part des pouvoirs publics, des prestataires de services et autres, de manière à ce que l'on puisse suivre et mesurer dans le temps les progrès vers les buts établis. Elsie Bastien a signalé que :

> *Nous devons développer de données de base sur l'utilisation des services et des programmes par les populations autochtones. Il est important d'élaborer des mécanismes permettant de recueillir et d'analyser de l'information longitudinale sur la santé des Autochtones. Une approche ciblée et centralisée permettra d'assurer la coordination, de favoriser la comparabilité et d'établir des liens entre la santé des Autochtones et les sources des données*[290].

Le Comité estime que, faute d'un tableau clair, complet et exact de la situation dans laquelle se trouvent actuellement les populations indiennes, inuites et métisses, il sera extrêmement difficile de fixer des normes et des cibles et de prévoir les ressources nécessaires pour mettre sur pied des programmes et services qui amélioreront effectivement le bien-être général des peuples autochtones.

Les témoins ont insisté sur la nécessité d'établir des données propres à chaque groupe. L'Enquête régionale longitudinale sur la santé des Premières nations a été présentée comme un moyen de réunir de façon régulière des données sur la santé mentale et de suivre les progrès en matière d'égalité d'accès aux services de santé mentale dans les collectivités des Premières nations. Menée au Centre des Premières nations de l'Organisation nationale de la santé autochtone, cette enquête régionale est

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289 21 avril 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/13evb-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

290 9 juin 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/21evb-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

axée sur la collectivité et constitue la seule enquête visant les réserves et réunissant des données directement auprès des peuples des Premières nations.

Il existe peu de données sur la santé mentale des Inuits et des Métis, et d'ailleurs aussi sur les autres dimensions de la santé de ces groupes. Il est très difficile de mesurer les progrès lorsque l'on manque de données ou que celles-ci sont insuffisantes.

> *Pour les Inuits plus précisément, nos données manquent ou sont mélangées avec les données concernant les autres peuples autochtones. Sans les bonnes statistiques sur la santé inuite, la conception et l'évaluation de programmes et services ne reposeront pas sur des données sûres. — Larry Gordon*[291].

> *De façon générale, alors que nous recueillons des données et que nous constituons une base de données fondée sur l'expérience des Premières nations et des Inuits, nous accusons un retard pour ce qui est de la collecte de données essentielles de base sur les Métis. — Bernice Downey*[292].

Le Comité ne comprend pas comment les ministères fédéraux, conscients de l'effroyable état de santé des peuples autochtones et du fait que ce segment de la population est considéré de façon universelle comme menacé, peuvent ne pas avoir réuni, ni appuyé la collecte par d'autres organismes, des données nécessaires pour élaborer une stratégie propre d'abord à régler véritablement le problème, puis à mesurer les progrès vers l'atteinte des résultats.

Un témoin a insisté sur la nécessité d'analyser soigneusement les données en tenant compte de facteurs comme la culture. Elsie Bastien a fait remarquer qu'une évaluation de la prestation de services peut être jugée comme piètre si la théorie de départ est imparfaite :

> *Une erreur ou un résultat médiocre indique que les données sont incomplètes ou que l'hypothèse est inadéquate, ce qui a empêché l'atteinte d'un certain objectif ou la concrétisation d'une intention. Il est essentiel que des indicateurs de programme adaptés aux réalités culturelles fassent partie de l'analyse du milieu proposée.*
>
> *Pour obtenir une idée exacte de la situation, il ne faut pas utiliser les données provenant d'un modèle médical occidental, ce qui est la pratique*

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291 21 avril 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/13evb-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

292 21 avril 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/13evb-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

actuelle, mais des données provenant d'une perspective autochtone sur la santé et le bien-être[293].

Le Comité estime que, faute d'un tableau clair, complet et exact de la situation dans laquelle se trouvent actuellement les populations indiennes, inuites et métisses, il sera extrêmement difficile de fixer des normes et des cibles et de prévoir les ressources nécessaires pour mettre sur pied des programmes et services qui amélioreront effectivement le bien-être général des peuples autochtones. Il reconnaît tout particulièrement qu'il est important de réunir des données qui fourniront une base de référence à partir de laquelle il sera possible de suivre dans le temps les nouveaux investissements et de mesurer les résultats des nouveaux programmes et services.

Le Comité ne comprend pas comment les ministères fédéraux, conscients de l'effroyable état de santé des peuples autochtones et du fait que ce segment de la population est considéré de façon universelle comme menacé, peuvent ne pas avoir réuni, ni appuyé la collecte par d'autres organismes, des données nécessaires pour élaborer une stratégie propre d'abord à régler véritablement le problème, puis à mesurer les progrès vers l'atteinte des résultats.

Le Comité recommande donc :

101	**Que le gouvernement du Canada travaille avec l'Organisation nationale de la santé autochtone à l'évaluation de la pertinence de l'enquête régionale sur la santé des Premières nations, comme modèle de collecte de données sur d'autres peuples autochtones.** **Que l'Institut canadien d'information sur la santé soit encouragé à fournir une analyse des déterminants de la santé pour chacun des peuples autochtones** **Que la Commission canadienne de la santé mentale (voir le Chapitre 16) collabore avec l'Institut canadien d'information sur la santé pour que l'on comprenne mieux les causes et l'incidence des maladies mentales.**

14.9.2 Remanier le financement

Des témoins ont répété à maintes reprises qu'un financement suffisant, souple et permanent est la clé du développement du potentiel des Autochtones. Il faut notamment un financement durable pluriannuel; en effet, dans la pratique, des collectivités ont consacré des ressources à l'établissement d'un

Il faut un financement durable pluriannuel; en effet, dans la pratique, des collectivités ont consacré des ressources à l'établissement d'un programme pour découvrir que le financement n'était offert que pendant une année ou deux.

[293] 9 juin 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/21evb-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

programme pour découvrir que le financement n'était offert que pendant une année ou deux. Onalee Randell a expliqué :

> *Le financement incertain à court terme crée rend extrêmement difficile la prestation de programmes de santé mentale...le financement pluriannuel flexible est nécessaire. Il est difficile pour les petites collectivités d'élaborer des programmes sans savoir si ces programmes seront financés l'année suivante*[294].

Valerie Gideon a appelé à une transformation des structures de financement et de présentation de rapports :

> *... pour aider au lieu d'empêcher la mise en oeuvre par les collectivités d'approches holistiques à la santé mentale. Les dispositions en matière de financement pluriannuel flexible et les rapports fondés sur des résultats et non sur des données administratives sont des exemples de cette transformation*[295].

Irene Linklater a noté que des modèles intégrés de financement entre organismes fédéraux sont mis en place et appuient des programmes généraux dotés de rigoureuses exigences en matière de reddition de comptes et de financement soutenu à long terme :

> *...il existe un nouveau modèle de contribution entre la Direction générale de la santé des Premières nations et des Inuits et Affaires indiennes et du Nord Canada qui touche au financement global et aux ententes pluriannuelles. Ce processus nous encourage*[296].

Il faut des formules de financement axées sur les besoins qui assurent un financement stable et prévisible de manière à faciliter la planification financière.

La vérificatrice générale du Canada a critiqué les exigences en matière de rapport fixées par le gouvernement fédéral, estimant que celles-ci « représentent un lourd fardeau pour les Premières nations, surtout pour les collectivités qui comptent moins de 500 résidents. Selon nos estimations, les quatre organismes fédéraux qui fournissent la majorité du financement pour les grands programmes fédéraux exigent au moins 168 rapports »[297].

Il faut des formules de financement axées sur les besoins qui assurent un financement stable et prévisible de manière à faciliter la planification financière. Valerie Gideon a déclaré

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294 20 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/27eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

295 20 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/27eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47

296 1er juin 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/16evc-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

297 Vérificatrice générale du Canada (décembre 2002), « Repenser les rapports soumis par les Premières nations aux organismes fédéraux », http://www.oag-bvg.gc.ca/domino/rapports.nsf/html/20021201cf.html.

appuyer la tendance à un financement de la santé des Premières nations plus ciblé et fusionné et à un financement de base ainsi que le projet d'élaborer un « réseau de centres et de pavillons de ressourcement relevant de la responsabilité des Premières nations afin d'établir des passerelles entre les différentes administrations et les ministères individuels, de sorte que les ressources consacrées aux programmes de santé et sociaux puissent être regroupées ». Elle a affirmé que ce financement serait le plus efficace s'il s'accompagnait :

> *... [d'] une augmentation du transfert du financement aux collectivités des Premières nations pour développer et entretenir leurs propres établissements de santé et les services en santé mentale au moyen de liens stratégiques établis avec les compétences provinciales et territoriales* [298].

Plusieurs témoins ont contesté la façon dont les fonds étaient affectés à la santé mentale de manière générale. Donna Lyon a remis en question l'importance attachée actuellement à l'abordabilité plutôt qu'aux besoins, alors que les besoins en services de santé mentale sont criants[299].

Selon Ron Evans, le financement peut favoriser le bien-être. Il a lié les recherches menées par l'Université Harvard sur le développement socio-économique et en Colombie-Britannique sur la prévention du suicide chez les Premières nations de manière à démontrer la corrélation entre la stabilité économique et culturelle dans les collectivités :

> *La recherche de Harvard sur les tribus autochtones américaines a révélé, après plusieurs années de travail sur place dans les Premières nations des États-Unis et du Canada, que le succès des entreprises dans les Premières nations au Canada et dans des tribus aux États-Unis dépendait de quelques facteurs tels que la stabilité du gouvernement et de la réglementation, d'un financement approprié et, surtout, d'une adaptation culturelle de l'entreprise à la collectivité. De même, l'étude que Chandler et Lalonde ont consacrée sur une période de 14 ans à la continuité culturelle en tant qu'agent protecteur contre le suicide a constaté que les Premières nations qui exercent un contrôle sur des fonctions essentiellement gouvernementales telles que l'éducation, la santé, les services communautaires, qui ont œuvré pour résoudre les revendications territoriales et qui pratiquent activement leurs traditions culturelles, connaissent un taux de suicide nul ou très bas*[300].

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298 20 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/27eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

299 20 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/27eva-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

300 31 mai 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-f/soci-f/16evb-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

14.9.3 Financement destiné aux jeunes

Irene Linklater était l'une des quelques témoins qui a évoqué l'absence de financement expressément prévu pour les jeunes et les problèmes créés par les retards dans le financement de programmes. À propos de l'importance des conseils qui représentent les jeunes dans les collectivités, elle a affirmé :

> *Parmi les problèmes auxquels ils font face, mentionnons les difficultés d'accès au financement. Il n'y a pas vraiment de fonds alloués spécifiquement à des activités visant à mobiliser les jeunes à l'échelle communautaire, par exemple dans le cadre de stratégies de la prévention du suicide chez les jeunes.*
>
> *Ici même, au Manitoba, nous avons des fonds offerts aux jeunes par l'entremise de l'Assemblée des Chefs du Manitoba, mais nous devons nous battre chaque année pour obtenir ce financement. Il arrive parfois que nous le recevions seulement en octobre*[301].

Jason Whitford, coordonnateur, Conseil de la jeunesse, Assemblée des chefs du Manitoba, a reconnu qu'il ne faut pas forcément beaucoup d'argent pour mener des projets constructifs dans une collectivité, mais que toute interruption du financement complique le fonctionnement des projets. Même la Keewatin Winnipeg Youth Initiative, reconnue comme un projet exemplaire et financée par l'Initiative des centres urbains polyvalents pour les jeunes autochtones de Patrimoine canadien, a connu des problèmes de financement :

> *Nous nous attendons cette année encore à recevoir du financement. Nous perdrons probablement cinq mois de l'année. Cependant, d'après notre expérience, nous avons l'intention de continuer à dispenser les programmes et services aux jeunes Autochtones en milieu urbain et de convaincre la direction de l'ACM de nous appuyer dans la mise en œuvre du projet*[302].

Pour les Inuits aussi, le financement n'est pas régulier, bien que la présence et la participation des jeunes soient perçues comme cruciales pour le bien-être de la collectivité. Larry Gordon a montré comment le National Inuit Youth Council avait participé activement à l'établissement de modèles de rôles et à la prévention du suicide.

> *Le financement dont bénéficient les jeunes pour ces activités importantes est versé annuellement, sans garantie de reconduction, malgré les succès obtenus grâce au travail de sensibilisation des jeunes Inuits qui*

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301 1er juin 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/16evc-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

302 31 mai 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/16evb-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

constituent la population la plus vulnérable au suicide de tout le Canada[303].

Dans le cadre de l'entente conclue en septembre 2004 par les gouvernements fédéral, provinciaux et territoriaux sur la santé, le gouvernement fédéral a annoncé un nouveau financement de 65 millions de dollars et portant sur cinq ans devant permettre de mettre sur pied une stratégie de prévention du suicide chez les jeunes autochtones. Ian Potter a noté tout particulièrement que :

> *Ce projet sera réalisé avec la participation de l'Assemblée des Premières nations et l'Inuit Tapiriit Kanatami avec la collaboration d'autres organisations autochtones nationales, des provinces, des territoires et de certains ministères fédéraux. Cette stratégie vise à aider les collectivités à empêcher les tendances suicidaires de se développer chez les jeunes, à communiquer avec les jeunes qui sont susceptibles de se suicider et à prévenir les suicides en série après qu'un suicide se soit produit.*[304].

Pour Arnold Devlin, il est cependant très préoccupant que le financement de programmes visant un problème aussi grave que le suicide cesse après cinq ans :

> *L'un de nos plus grands soucis, c'est la viabilité du programme; il doit être appuyé par une planification à long terme, qui sera la clé du succès. Si nous pensons qu'il constitue toute la solution, il sera sans efficacité*[305].

14.9.4 Recommandations

Le Comité estime comme allant de soi qu'il faille investir à long terme pour guérir les souffrances qu'ont subies les peuples autochtones. Depuis longtemps, les pouvoirs publics qui sont responsables du bien-être de ces derniers, notamment le gouvernement fédéral, manifestent en alternance indifférence et attention à leur endroit. Le Comité connaît les engagements pris en novembre 2005 dans le cadre du Plan directeur de la santé des Autochtones. Il sait toutefois aussi que les annonces antérieures comme celle de septembre 2004 visant à doter de 200 millions de dollars un fonds pour l'adaptation des services de santé à l'intention des Autochtones n'ont guère répondu aux besoins en la matière des peuples autochtones. Les discussions concernant la répartition de ces fonds se poursuivent toujours, quelque 14 mois plus tard. Pendant ce temps, les problèmes ne se règlent pas et ils s'aggravent probablement. Mais nous n'avons aucune donnée sur la question.

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303 21 avril 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/13evb-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

304 Ian Potter, Sous-ministre adjoint, Direction générale de la santé des Premières nations et des Inuits, Santé Canada, lettre au sénateur Michael Kirby, président, Comité sénatorial permanent des Affaires sociales, des sciences et de la technologie, 7 février 2006, p.2.

305 20 septembre 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-f/soci-f/27evb-f.htm?Language=F&Parl=38&Ses=1&comm_id=47.

Le Comité a pris bonne note des appels pressants à un financement pluriannuel et soutenu qui tienne compte de l'ampleur des problèmes que connaissent les peuples autochtones. Il a déjà recommandé que la Commission canadienne de la santé mentale proposée, en consultation avec son Comité consultatif des Autochtones, établisse des calendriers et des niveaux de financement en vue de la mise en place de programmes de bien-être et de guérison. Il appelle à une application rapide de cette stratégie globale et de ce plan d'action.

Le Comité a déjà recommandé la création d'un comité interministériel qui devra présenter un rapport bisannuel au Parlement, où il précisera les programmes et services fédéraux en cours et les fonds qui y sont consacrés. Il a aussi recommandé que le gouvernement fédéral identifie, en collaboration avec les peuples autochtones, les programmes et services nécessaires et les critères d'évaluation et de surveillance pertinents.

Le Comité recommande également :

102	**Que le gouvernement du Canada analyse immédiatement le niveau actuel du financement fédéral consacré aux peuples autochtones.** **Que ces analyses portent sur le financement nécessaire pour changer les principaux déterminants de la santé des peuples autochtones.** **Que ces analyses comprennent des évaluations à court, à moyen et à long terme des besoins de financement.** **Que le premier rapport que le Comité interministériel soumettra au Parlement (voir section 14.6.3) présente les résultats de ces analyses.**

14.10 CONCLUSION

Dans un pays fier de la multitude de possibilités qui s'offrent à la plupart de ses citoyens et de la richesse de ses ressources humaines et naturelles, les difficultés qui sont le lot quotidien des peuples autochtones sont une honte nationale.

Dans un pays fier de la multitude de possibilités qui s'offrent à la plupart de ses citoyens et de la richesse de ses ressources humaines et naturelles, les difficultés qui sont le lot quotidien des peuples autochtones sont une honte nationale. Il y a pourtant raison d'espérer. Le Comité a appris que les peuples autochtones connaissent une détresse mentale extrême, mais qu'ils affichent peu de troubles mentaux. Il est donc fort probable que l'on puisse remédier à bon nombre des problèmes que ces peuples connaissent actuellement, que ce soit le suicide ou la toxicomanie lié au désespoir. Les peuples autochtones présentent un potentiel humain énorme, en raison surtout de leur jeunesse.

Les peuples autochtones présentent un potentiel humain énorme, en raison surtout de leur jeunesse.

Le Comité a été encouragé par des témoignages répétés selon lesquels il est possible d'éviter la détresse mentale des peuples autochtones et d'atténuer les effets de décennies de traitement morcelé et souvent négatif. Il convient que les efforts des pouvoirs publics, des

collectivités et des particuliers peuvent avoir des effets constructifs sur le bien-être, surtout celui découlant d'une bonne santé sur le plan mental.

Le Comité est d'avis que l'Initiative sur la santé de la population canadienne, mise sur pied il y a quelque temps déjà, est très prometteuse et permet d'espérer de fortes améliorations de l'état de santé physique et mentale des peuples autochtones, à la faveur essentiellement de transformations concrètes de leurs conditions de vie sociales et matérielles. Des interventions dans les domaines de l'éducation, du logement, de l'emploi et de l'appui à la collectivité peuvent produire des avantages à long terme importants pour les peuples autochtones.

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Le Comité est au courant de nombreuses mesures prises par les collectivités autochtones d'un peu partout au pays en vue de changer leur situation sociale et matérielle. Il reconnaît également la collaboration qui se maintient entre tous les groupes — Premières nations, Métis, et Inuits. Le Comité félicite tous les participants à ces entreprises conjointes.

Le Comité croit fermement en la mise sur pied d'une stratégie nationale qui soit holistique, adaptée à la culture, fondée sur la collectivité, équitable pour l'ensemble des peuples autochtones et appuyée par un financement soutenu. Il appelle à la préparation d'un plan d'action fondé sur les déterminants de la santé, qui comprenne des buts et des calendriers précis de manière à en arriver à des avantages mesurables et qui encourage la collaboration entre toutes les parties de manière à atteindre ces objectifs.

Le Comité appuie la conclusion d'ententes de financement pluriannuelles stables et plus vastes qui assureront un soutien à long terme aux objectifs sur longue durée d'une population qui connaît des problèmes graves mais évitables. Il sait que l'ensemble des Canadiens souhaite que l'on avance dans cette voie et que l'on améliore le bien-être global des peuples autochtones.

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